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Supreme Court, U.S.
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In The Supreme Court Of The United States

OCTOBER TERM, 1996

THE MARYLAND PSYCHIATRIC SOCIETY, INC.,

Petitioner,

v.

MARTIN P. WASSERMAN, M.D., J.D., Secretary, Maryland Department of Health and Mental Hygiene,

and

DONNA E. SHALALA, Secretary, United States Department of Health and Human Services,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Are providers of Medicare Part B services to the low-income Qualified Medicare Beneficiaries ("QMBs") entitled to reimbursement at the Medicare-approved fee schedule rate for such services?

2. Did the Fourth Circuit misapply *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 101 S.Ct. 1531, 67 L.Ed.2d 694 (1981) as a basis for reversing the District Court in this case?

3. Did Congress create a statutory scheme that provides for non-payment of 37.5% of Medicare-approved fees for outpatient mental health services furnished to the elderly or disabled poor?

PARTIES TO THE PROCEEDING

The names of all parties are listed in the caption and style of the case.[1]

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[1] Petitioner filed a "Disclosure of Corporate Affiliations and Other Entities With a Direct Financial Interest in Litigation" in the U.S. Court of Appeals for the Fourth Circuit on October 2, 1995. Petitioner included a copy of this "Disclosure" in its "Brief of Appellee" filed in the Fourth Circuit on March 18, 1996. Petitioner certified that it is not a publicly held corporation or entity; that it is not the parent, subsidiary, or affiliate of, or a trade association representing, a publicly held corporation or entity; and that there was no other publicly held corporation or entity that had a direct financial interest in the outcome of the litigation.

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PETITION FOR WRIT OF CERTIORARI

The Maryland Psychiatric Society, Inc., hereby petitions this Court for a writ of *certiorari* to review the decision of the United States Court of Appeals for the Fourth Circuit in this case.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Fourth Circuit, dated December 16, 1996, is reported at *The Maryland Psychiatric Society, Inc. v. Martin P. Wasserman, et al.*, 102 F.3d 717 (4th Cir. 1996). App. 1. The Memorandum Opinion of the United States District Court for the District of Maryland, dated August 21, 1995, is not reported. App. 28.

III. JURISDICTION

The decision of the United States Court of Appeals for the Fourth Circuit was issued on December 16, 1996. App. 1. An Order denying Petitioner's timely Petition for Rehearing and Suggestion for Rehearing *In Banc* was entered on February 11, 1997. App. 24. This Court has jurisdiction under 28 U.S.C. §1254(1).

STATUTORY PROVISIONS

Pertinent provisions of Titles XVIII and XIX of the Social Security Act, known as the Medicare Act (42 U.S.C. §1395, *et seq.*) and the Medicaid Act (42 U.S.C. §1396, *et seq.*), respectively, are set out in the Appendix. App. 83.

STATEMENT OF THE CASE

This case is about access by the elderly and disabled poor to necessary mental health services. Access to such services is provided by State Medicaid programs in conjunction with the federal government under Medicare Part B to "Qualified Medicare Beneficiaries" ("QMBs"), *i.e.*, people who qualify for Medicare and who also live below the federal poverty line. Congress required State Medicaid programs to pay QMBs' share of Medicare costs, as a condition of the States' participation in Medicaid and receipt of matching funds from the federal government. The requirement that States pay QMBs' costs at the Medicare rate ensured health care providers' recovery of their Medicare-allowed fees.

Under the Fourth Circuit's ruling in this case, however, 37.5% of the Medicare-approved fees incurred by QMBs for outpatient mental health services are left unpaid by the State and federal governments. Health care providers cannot, legally or practically, collect the unpaid 37.5% of their Medicare-allowed fees from QMBs. Petitioner challenges the Fourth Circuit's impairment of the availability of outpatient mental health services to impoverished Medicare beneficiaries.

A. Procedural Background

On March 24, 1995, Petitioner filed a lawsuit against Respondents, Martin P. Wasserman, the Secretary of Maryland's Department of Health and Mental Hygiene ("Maryland") and Donna E. Shalala, the Secretary of the U.S. Department of Health and Human Services ("HHS"). The lawsuit was filed on behalf of Petitioner's members, psychiatrists who provide outpatient mental health services to the low income population of the State of Maryland. The lawsuit sought declaratory and prospective injunctive relief to compel compliance with federal law

governing payment for certain Medicare services provided by Petitioner's members. Specifically, for outpatient mental health services provided by Petitioner's members to Medicare beneficiaries below the poverty line, the federal government's Medicare program made its standard 50% payment. Petitioner sought to compel a combined federal and state "cost-sharing" payment of the remaining 50% of Medicare-approved fees for these services, as Congress has declared that QMBs are too poor to pay this amount, that Medicaid-participating States are obligated to pay costs for which QMBs would be responsible if they were non-QMB Medicare beneficiaries, and as providers are legally and practically unable to collect this amount from QMBs. In 1992, HHS had abandoned its policy that States, with the assistance of federal matching funds, were responsible for paying the 50% cost-sharing, at least up to the Medicaid rate, and adopted, for the first time, a reimbursement policy under which Petitioner's members only received 12.5% of the Medicare-approved amount as Maryland's and HHS' "cost-sharing" payment. Petitioner's members thus absorbed a 37.5% loss on

such services. The United States District Court for the District of Maryland assumed jurisdiction of this matter pursuant to 28 U.S.C. Sections 1331, 1343, 2201 and 2202.

On August 21, 1995, the District Court ruled in favor of Petitioner. The District Court declared that the 37.5% of the Medicare fee schedule amount left unpaid under the challenged method of reimbursement was "Medicare cost sharing" within the meaning of 42 U.S.C. §1396d(p)(3). App. at 75. The District Court also permanently restrained and enjoined Maryland and HHS from enforcing any policy or interpretation of 42 U.S.C. §1395*l*(c) and 42 U.S.C. §1396d(p)(3) that was inconsistent with the terms of its Order. App. 34. Both Maryland and HHS appealed.

The panel of the Court of Appeals for the Fourth Circuit reversed the District Court's. App. 22. The Court of Appeals also denied Petitioner's Petition for Rehearing and Suggestion for Rehearing *In Banc*. App. 24.

B. Statutory and Factual Background

(I) The Medicare Program. Part B of the

Medicare program is a voluntary program of supplementary insurance in which Medicare-eligible people may enroll and which covers outpatient physician services. 42 U.S.C. §§ 1395j-1395w. The beneficiary is generally required to pay a premium and an annual deductible for covered services. The federal government pays a specified percentage of providers' "fee schedule" "charges." Beneficiaries pay the balance, which Congress has stated is "coinsurance". *Infra.*

(ii) The Medicaid Program. The Medicaid program is funded by both the federal and state governments. States choosing to participate in Medicaid must adhere to Congressional mandates. States participating in Medicaid are required to provide insurance coverage for many medical services, including physician services. 42 U.S.C. § 1396a(a)(10)(A).

(iii) Dual Eligibles and QMBs. As to beneficiaries who also meet the financial requirements for Medicaid, Congress required that States participating in Medicaid enroll such "dual eligibles" in Medicare Part B. Because such individuals are

unable to pay the Part B premiums, Congress established "buy-in" agreements between HHS and the States, which require that the States pay the premiums. 42 U.S.C. § 1395v. Congress also required that states assume dual eligibles' obligations to pay Medicare deductibles and coinsurance. 42 U.S.C. §1396a(a)(10)(E).

In 1986, Congress recognized that many Medicare-eligible people who were not so poor as to be eligible for Medicaid, nevertheless were too poor to pay their share of Medicare costs, and thus often went without the benefits that Medicare Part B provides. H.R. No. 727, 99th Cong., 2d Sess., *reprinted in*, 1986 U.S.C.C.A.N. 3607, 3692-96. Congress designated this class of low income Medicare beneficiaries "Qualified Medicare Beneficiaries" ("QMBs"), and authorized State Medicaid programs to enroll such people in the Medicare Part B program in just the same way as the States enrolled Medicaid-eligible people. *See*, Omnibus Budget Reconciliation Act of 1986, P.L. 99-509, 100 Stat. 1874.

The Medicare Catastrophic Coverage Act of

1988, P.L. 100-360, 102 Stat. 683, made it mandatory that States buy Part B coverage and assume the "cost-sharing" liability of QMBs as a condition of receiving federal Medicaid funds. The definition of "QMB" was broadened to include all Medicare-eligible individuals whose incomes fall below federal poverty levels, whether or not also eligible for Medicaid. P.L. 100-647, 102 Stat. 3342, 3805; Technical and Miscellaneous Revenue Act of 1988, § 8434(a).

(v) Limitations on Charging QMBs Under the Medicaid Act. The Medicaid Act essentially bars providers from charging QMBs for services provided under Medicare Part B. 42 U.S.C. §1396o.[2]

(vi) Cost-Sharing . The "cost-sharing" payments which Medicaid-participating States must make on behalf of QMBs are statutorily defined at 42 U.S.C. § 1396d(p)(3). App. 38. The phrase includes certain specified premiums, coinsurance under Medicare Part A and Part B, deductibles, and the

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[2] This bar is subject to a minor caveat under which, in certain limited circumstances, certain "nominal" charges may be imposed on beneficiaries.

Medicare Part B copayment, which is typically 20%. 42 U.S.C. § 1396d(p)(3).

(vii) The "Reduction" of Medicare Payments Relating to "Outpatient Psychiatric Services".

42 U.S.C. § 1395*l*(a) specifies the amount of the Federal payment under Medicare Part B for Medicare beneficiaries in general. 42 U.S.C. § 1395*l*(b) specifies the annual deductible imposed on individuals insured under Part B. The Federal government provides primary insurance coverage subject to the deductible in subsection (b). Typically, the federal insurance payment is 80% of fee schedule costs or charges, but the percentage of the federal insurance payment is reduced with regard to certain "mental disorders":

> c. Mental disorders.
>
> Notwithstanding any other provision of this part, with respect to expenses incurred in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not a patient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections (a) and (b), only 62 ½

> of such expenses. 42 U.S.C. § 1395*l*(c). (Emphasis added.)

Importantly, however, 42 U.S.C. §1395*l* does not address the "cost-sharing" liability of QMBs that the States must assume as a condition of receiving federal Medicaid funds. *See*, 42 U.S.C. §1396a(a)(10)(E).[3]

(viii) Relevant Legislative History with Regard to "Coinsurance" for Outpatient Mental Health Services

Congress intended that Medicare Part B would pay 50% of providers' Medicare-approved charges for outpatient mental health services and that beneficiaries would be responsible for the remaining "50% coinsurance". Providers would obtain total reimbursement from Medicare Part B and their

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[3]Nor does 42 U.S.C. §1395*l* address the federal government's obligation to pay a portion of the States' cost-sharing liability for QMBs. *See*, 42 U.S.C. §1396d(b): "[T]he Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum."

patients. When enacting the Medicare Catastrophic Coverage Act of 1988, Congress amended 42 U.S.C. § 1395*l*(c) to increase the then-existing limit on total expenditures for outpatient psychiatric services within a calendar year [which has since been repealed]. Congress stated:

> Under current law the maximum reimbursement for services provided by a psychiatrist or non-psychiatric physician providing for outpatient treatment of mental, psychoneurotic, or personality disorder is $250 per calendar year for each Medicare beneficiary. Medicare only recognizes a maximum of 62.5% of $500 of such charges, or $312.50, and will reimburse 80 percent of this amount or $250. Consequently, the effective coinsurance rate is 50 percent for the first $500 of outpatient mental health services. H.R. No. 100-105(l), § 203, *reprinted in*, 1988 U.S.C.C.A.N. at p. 826. (Emphasis added.)

Congress retained the imposition of 50% coinsurance responsibility on Medicare beneficiaries:

> The coinsurance requirement, [*i.e.*, the 50% referred to in the House Report immediately above] would remain the same. Thus, Medicare would recognize up to 62.5% of $2,000 of charges or $1250, and would reimburse 80 percent of this amount, or $1,000 [leaving the 50% coinsurance of $1000 as the responsibility of the beneficiary]. H.R. No.

> 100-105(l), § 203, *reprinted in*, 1988 U.S.C.C.A.N. at 826.(Emphasis added.)

In 1989, Congress again dealt with the "outpatient psychiatric services" reduction:

> Psychotherapy and other treatments for mental illnesses and disorders are covered under Medicare Part B, subject to various provisions that can be a restraint on access. Services provided by psychologists are currently covered only in community mental health centers. In addition, the patient is responsible for 50% coinsurance, instead of the standard 20%, and the maximum amount of Medicare reimbursement is $1,100 per year.
> The Committee bill would expand access to mental health benefits through several measures. It would eliminate the $1,100 annual limit, while retaining the 50 percent coinsurance. . . . H.R. 101-247, § 4021, *reprinted in*, U.S.C.C.A.N. at 2087. (Emphasis added.)

States must pay as Medicare "cost sharing" those amounts for which QMBs would be responsible if they were non-QMB Medicare beneficiaries, *infra*. Thus, these Congressional statements show that the State and federal governments are responsible for 50% of Medicare-allowed fees for outpatient mental health services in satisfaction of their "cost sharing"

obligations.

(ix) HHS' 1989 Interpretation of 42 U.S.C. § 1395*l*(c) and 42 U.S.C.§ 1396p(d)(3).

In 1989, HHS was asked whether States' cost sharing responsibility for outpatient mental health services was 20% of 62.5% of reasonable charges, or whether cost sharing included that amount plus the remaining 37.5% of "approved" charges. App. 173.

In 1989, HHS articulated the following policy:

> While the 37.5% of approved charges referred to is not usually called a coinsurance in Medicare administrative issuances, that is what it, in fact, is. Therefore, the State is responsible for 37.5% of the approved charges, plus 20 percent of the remainder of those charges, for outpatient psychiatric services, in the situation described. App. 173. (Emphasis added.)

In its 1989 Memorandum, HHS also opined that States could limit the coinsurance payments so that the total payment to providers was capped at the Medicaid rate rather than the Medicare rate. The Medicaid rate was typically 80% of the Medicare rate. Until 1993, Maryland and the federal government paid Petitioner's members the full Medicaid amount for outpatient mental health services to QMBs. App. 159-

162.

(x) HHS' and Maryland's Current Interpretation of 42 U.S.C. § 1395*l*(c) and 42 U.S.C. § 1396(d)(p)(3).

In 1992, HHS "set . . . aside the position HCFA took in our Memorandum of April 7, 1989 . . . on this subject." App. 172. Beginning in 1993, Maryland and the federal government paid only 12.5% of the fee schedule amount as "cost sharing" to providers of outpatient psychiatric services to QMBs. Thus, Petitioner's members were not reimbursed for 37.5% of their Medicare-approved fees for services provided to QMBs from 1993 until the District Court ruled in favor of Petitioner. App. 72.

REASONS WHY THE PETITION SHOULD BE GRANTED

The decision below conflicts with decisions by the Second, Third, Ninth and Eleventh Circuits holding that providers of Medicare Part B services to QMBs are entitled to full reimbursement at the Medicare fee schedule rate, and it creates a lack of uniformity in treatment under a national program. Moreover, the Fourth Circuit departed from other

Circuits' decisions based on a misapplication of *Pennhurst*, which raises an important issue of federal law of broad consequence beyond the context of the particular statutes at issue in this case. Finally, the issue of whether "cost-sharing" for outpatient mental health services is 50% or 12.5% of the fee schedule amount, is itself an important issue of federal law which this Court should settle. The consequence of the Court of Appeals' ruling is that 37.5% of psychiatrists' Medicare-approved fees for services provided to QMBs will go unpaid, which will inevitably render such services less available to QMBs. Such a diminution of access to quality medical care based on patients' lack of wealth is precisely the problem Congress sought to alleviate when it created the QMB program.

ARGUMENT

I. The Decision Below Creates Conflicts Among the Lower Courts on Issues of Great Public Importance.

The Fourth Circuit's decision in this case conflicts with decisions of the Second, Third, Ninth, and Eleventh Circuits that establish two fundamental

principles. *See, New York City Health & Hospitals Corp. v. Perales*, 954 F.2d 854 (2d Cir. 1992); *Pennsylvania Medical Society v. Snider*, 29 F.3d 886 (3d Cir. 1994); *Haynes Ambulance Service, Inc. v. State of Alabama*, 36 F.3d 1074 (11th Cir. 1994); and *Stephenson v. Shalala*, 87 F.3d 350, 352 (9th Cir. 1996). First, in *Haynes* and *Snider*, the Eleventh and Third Circuits held that states must pay the full amount that constitutes the difference between the Federal government's Medicare Part B payment and the "reasonable charge" for services established at 42 U.S.C. §1395w-4. *Haynes*, 39 F.3d at 1076; *Snider*, 29 F.3d at 894. The *Snider* Court also ruled that States must pay all of the Medicare-approved reasonable charges that are the responsibility of a non-QMB Medicare beneficiary. *Id.* The decision below allows states to avoid paying on behalf of QMBs 37.5% of the costs and charges for which non-QMB patients would be responsible.

Second, the Second, Third, Ninth and Eleventh Circuits have all held that health care providers are entitled to charge and collect 100% of their reasonable

charges for Medicare Part B services to QMBs. The Second Circuit relied, in part, on 42 U.S.C. §1396(a)(a)(10)(E), in so ruling. *Perales*, 952 F.2d at 859. The Eleventh Circuit found that health care providers' right to receive payment for 100% of their reasonable charges for Medicare Part B services to QMBs is grounded in 42 U.S.C. §1396a(a)(10)(E), 42 U.S.C. §1395*l* and 42 U.S.C. §1395w-4. *Haynes*, 36 F.3d at 1076. The Third Circuit, relying on 42 U.S.C. §1395*l*, 42 U.S.C. §1395w-4(a)(1), 42 U.S.C. §1395u(b)(3)(B), and 42 U.S.C. §1395cc(a)(2)(A), found that providers of Medicare services to QMBs were entitled to receive 100% of Medicare-approved reasonable charges. *Snider*, 29 F.3d at 891. *See, also, Stephenson*, 87 F.3d at 352 (42 U.S.C. §1395*l*(a)(2)(B(I) "guarantees health services providers payment for 100% of their Medicare-allowed costs.") In this case, however, the Fourth Circuit expressly rejected that basic principle, stating that the "assumption" that providers of Medicare Part B services to QMBs are entitled to recovery of charges for their services at the Medicare rate was "faulty".

App. 11.

The Fourth Circuit's decision also produces a disparate result on identical facts from that in a federal court in the State of Washington. There, the District Court held that the cost sharing amount for outpatient mental health services provided to QMBs includes the 37.5% of Medicare fee schedule charges. *See*, *South Sound Radiologists, Inc., et al.* v. *Jean T. Soliz, et al.* App. 35-37. The federal and state governments did not appeal the *Soliz* decision, and so are bound by the judgment. In Washington, therefore, as a result of a District Court decision, payment is made for the very amounts denied to providers in the Fourth Circuit.

The Medicare and Medicaid programs are national programs that should be administered in a uniform manner. Only this Court's review of the decision in this case can produce the requisite uniformity.

II. The Fourth Circuit's Use of *Pennhurst* as a Basis for Reversing the District Court was Legally and Factually Incorrect, and was Premised on a Statutory Misinterpretation.

A. The Fourth Circuit's Use of *Pennhurst* to Reverse the District Court was Legally Incorrect

The Fourth Circuit decision in this case rested upon language taken out of context from this Court's decision in *Pennhurst*. App. 9 et seq. Analysis of the *Pennhurst* ruling shows that it does not support the Fourth Circuit's reversal of the District Court. The Fourth Circuit also ignored cases in which this Court has interpreted statutory provisions with "undefined" terms, within complex statutes which imposed substantial financial obligations and/or consequences on the States, without applying *Pennhurst* in the manner advocated by the Fourth Circuit. *See, e.g.*, *School Board of Nassau County, Florida v. Arline*, 480 U.S. 273, 286 n. 15, 107 S.Ct. 1123, 94 L.Ed.2d (1987), *reh. den.*, 107 S.Ct. 1913, 95 L.Ed.2d 519; *Wright v. Roanoke Redev. & Housing Auth.*, 479 U.S. 418, 423, 107 S.Ct. 766, 93 L.Ed.2d 781 (1987); *Bennett v. Kentucky Dept. of Educ.*, 470 U.S. 656, 665-66, 105 S.Ct. 1544, 84 L.Ed.2d 590 (1985); and *Bell v. New Jersey*, 461 U.S. 773, 790 n. 17, 103 S.Ct. 2187, 76 L.Ed.2d 312 (1983).

In *Pennhurst*, this Court determined the question: "Did Congress intend in §6010 [of the Developmentally Disabled Assistance and Bill of Rights Act ("the Act"), 42 U.S.C. §6010] to create enforceable rights and obligations?" *Pennhurst*, 451 U.S. at 15. This Court noted: "[n]oticeably absent from §6010 is any language suggesting that §6010 is a "condition" for the receipt of federal funding under the Act". *Pennhurst*, 451 U.S. at 13. Thus, §6010 stood in "sharp contrast" with other sections of the Act, which included "mandatory" rather than "precatory" language. *Pennhurst*, 451 U.S. at 13, 18.

This Court determined that §6010 of the Act "simply does not create substantive rights" [or obligations], *Pennhurst*, 451 U.S. at 11, as "the general findings and declarations contained in a funding statute designed to encourage a course of conduct" should not be used by the federal courts "to create absolute obligations on the States." *Pennhurst*, 451 U.S. at 10. This Court explained "nothing in the Act or its legislative history . . . suggest[s] that Congress intended to require the States to assume" the

cost of providing "appropriate treatment" in the "least restrictive environment", as §6010 "spoke merely in precatory terms" "designed to encourage such a course of conduct". *Pennhurst*, 451 U.S. at 10, 18. This Court also relied, in part, on the absence of significant federal funding for what, in the Third Circuit's view, would have been "open ended" "burdensome" and "massive financial obligations" imposed on States. *Pennhurst*, 451 U.S. at 11, 17, 29.

Pennhurst has no application to the sharply different statutory provisions in this case, which are unequivocally phrased in mandatory terms. *E.g.*, "A State plan for medical assistance must - provide . . . for making medical assistance available for Medicare cost-sharing (as defined in section 1396d(p)(3) of this title) for qualified Medicare beneficiaries described in section 1396d(p)(1) of this title . . ." 42 U.S.C. §§1396a(a)(10)(E)(I). (Emphasis added.); "A State plan for medical assistance must - . . . provide that enrollment fees, premiums, or similar charges, and deductions, cost-sharing, or similar charges, may be imposed only as provided in section 1396o of this

title." 42 U.S.C. §1396a(a)(14). (Emphasis added.). Moreover, the Medicaid Act provides for federal funding commensurate with the financial obligations imposed on the States: "[T]he Federal medical assistance percentage [for the States' cost sharing payments] shall in no case be less than 50 per centum or more than 83 per centum." 42 U.S.C. §1396d(b) (Emphasis added.).

This Court distinguished *Pennhurst* in the context of health care providers' challenge to the State and federal governments' interpretations of "reimbursement" provisions of the Medicaid Act in *Wilder v. Virginia Hospital Association*, 496 U.S. 498, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990). *Wilder* involved an interpretation of the "Boren Amendment", which contains a host of undefined terms regarding which the providers' interpretation differed from that espoused by the State and federal governments. *Wilder*, 496 U.S. at 502-03, 507. The *Wilder* Court was called upon to determine whether the "Boren Amendment" created federal rights on the part of the providers, and concomitant obligations on the States,

enforceable under 42 U.S.C. §1983. *Wilder*, 496 U.S. at 509.

The *Wilder* Court distinguished *Pennhurst*. *Wilder*, 496 U.S. at 510-19. This Court noted that the applicable provisions of 42 U.S.C. §1396a are couched in "mandatory" rather than the "precatory" terms involved in *Pennhurst*. *Wilder*, 496 U.S. at 512. Furthermore, States' receipt of federal funds under 42 U.S.C. §1396d is "expressly conditioned on compliance" with the provisions of the Medicaid Act which mandate the "medical assistance" which must be provided under State plans. *Wilder*, 496 U.S. at 512. Thus, the Medicaid Act provisions which governed the contents of "medical assistance" plans and reimbursement to providers constituted a congressional command "wholly uncharacteristic of a mere suggestion or 'nudge'". *Wilder*, 496 U.S. at 512. The *Wilder* Court also ruled that Congress' allocation of only $1.6 million to Pennsylvania under the statute at issue in *Pennhurst*, "a sum woefully inadequate to meet the enormous financial burden of providing 'appropriate' treatment in the 'least

restrictive' alternative," was an important distinguishing factor which "supported the Court's conclusion [in *Pennhurst*] that Congress had a limited purpose in mind when it enacted §6010." *Wilder*, 496 U.S. at 511, n. 10. "By contrast, under the Medicaid program, the Federal Government provides funds to cover between 50% and 83% of the cost of patient care. See 42 U.S.C. §1396d . . . . In 1988, the federal contribution to the Medicaid program totaled approximately $29 billion." *Id.* Therefore, the *Wilder* Court did not apply *Pennhurst* to the Medicaid Act's "mandatory" provisions governing "medical assistance" plans and reimbursement to health care providers, and ruled that those Medicaid Act provisions create rights enforceable by providers and concomitant obligations on the States. *Wilder*, 496 U.S. at 510, 512, 524.

B. The Fourth Circuit Rested its *Pennhurst* Analysis on an Incorrect Factual Premise

The Fourth Circuit concluded that the District Court's ruling resulted in an "ambush of state treasuries" by suddenly, and for the first time,

requiring States to pay on behalf of the elderly poor the amount left unpaid after the federal government's Medicare program made its standard 50% payment. The history of state and federal reimbursement to providers of such services is to the contrary.

The Medicare Act, since its inception, has had a reduced Federal benefit for out-patient psychiatric services, and the co-insurance requirement for such services has always been higher than the standard 20%. However, the Medicaid Act, enacted at the same time as the Medicare Act, contains provisions which first enabled, and later required, states' Medicaid programs to buy Medicare Part B coverage for persons who were eligible both for Medicare and Medicaid. These persons were referred to as "dual eligibles," and the Medicaid Act, in 42 U.S.C. §1396a(a)(15)[since repealed], required state Medicaid programs which purchased Medicare Part B coverage for dual eligibles, to provide for payment of "all of any deductible, cost-sharing or similar charge . . . under Part B". For more than 20 years, the States satisfied this obligation, paying the amount left unpaid by federal Medicare, though many took the agency-

approved position, later invalidated by *Perales, Snider,* and *Haynes,* that these dual eligibles were primarily Medicaid insureds and that the co-insurance obligation could be capped at the Medicaid approved rate.

In 1988, the QMB amendments extended the states' obligations to pay "cost sharing" for Medicare eligible persons who lived below the federal poverty line. In 1989, HHS expressly directed state Medicaid programs to reimburse providers of outpatient psychiatric services to QMBs for the full amount left unpaid after application of the psychiatric reduction at least up to the Medicaid rate. App. 173.

The Medicaid rate of payment does not generally exceed 80% of the Medicare rate. Until 1993, providers of outpatient psychiatric services to QMBs in Maryland were reimbursed at the rate of 80% of their Medicare-approved reasonable charges, *i.e.*, at the full Medicaid rate. App. 159.

Maryland did not believe when it "signed up" for its Medicaid contract that it was only agreeing to pay 20% of 62.5%, *i.e.*, 12.5%, of the reasonable charges for outpatient psychiatric services to QMBs.

That was not what the federal government articulated to the states at the relevant time (App. 173), and that was not Maryland's interpretation of its payment obligation. App. 159. Until 1993, Maryland's Medicaid program paid Petitioner's members 30% of their reasonable charges for outpatient psychiatric services to QMBs, *i.e.*, Medicaid rate of 80% of Medicare rate - 50% federal payment under 42 U.S.C. §1395*l* = 30%. App. 159. Thus, the Fourth Circuit erred when it concluded that the District Court's ruling amounted to "redrafting" the terms of the Medicaid contract. App. 16. If anyone "redrafted" or "changed the terms" of the understood meaning of the relevant statutory provisions, it was HHS in 1992. App. 166.

C. The Fourth Circuit Also Erred in its Interpretation of the Particular Statutory Provisions Involved in this Case

The Fourth Circuit misapplied one tenet of statutory construction to force a result that is inconsistent with congressional intent. The Fourth Circuit also misconstrued the basic statutory terms at issue. The District Court properly found that the

"plain language" of the statutory terms at issue indicated that HHS' 1989 interpretation was correct. App. 56,70. The Fourth Circuit ignored the plain language of 42 U.S.C. §1396d(p)(3), and held that one could not accord the statutory terms their "plain language" meaning, as such a reading would cause some overlap between statutory provisions. App. 10. The Fourth Circuit ignored Congress' statements that: (1) the 50% [of Medicare-approved charges for outpatient mental health services] left unpaid after the Federal government makes its payment is coinsurance; (2) the 50% coinsurance for outpatient psychiatric services is identical to the "standard 20% coinsurance" except in amount; and (3) Medicare Part B beneficiaries who are not QMBs are responsible for reimbursing providers for 50% of reasonable charges for outpatient psychiatric services. (*See*, H.R. No. 100-105(1), §203, *reprinted in*, U.S.C.C.A.N. at p. 826; H.R. 101-247, §4021, *reprinted in* U.S.C.C.A.N. at 2087.)

The Fourth Circuit misapplied the general rule which counsels avoidance of of a statutory

interpretation that produces overlap between statutory provisions, if such overlap can be avoided while still reaching a result consistent with legislative intent. The Fourth Circuit concluded that "coinsurance" under 42 U.S.C. §1396d(p)(3)(b) could not include the "50% coinsurance" for outpatient mental health services referenced in the congressional record, because such a "plain language" reading of the statute would render 42 U.S.C. §1396d(p)(3)(d) "superfluous". App. 56. Thus, the Fourth Circuit construed 42 U.S.C. §1396d(p)(3), a statute which is designed to ensure participation by the elderly poor in Medicare Part B by requiring the States, with the assistance of federal matching funds, to pay on behalf of QMBs those costs for which non-QMB beneficiaries are responsible, in a manner that is directly contrary to the stated Congressional intent, because of a desire to avoid a perceived instance of legislative overlap.

The Fourth Circuit's analysis overlooks the fact that the Medicaid and Medicare Acts have been amended so many times that a certain amount of redundancy is inevitable. Furthermore, rules of statutory construction are tools to ascertain legislative

intent. Courts are not to manipulate or ignore legislative intent in order to promote fealty to a particular tenet of statutory construction, especially when adherence to other principles of statutory construction would produce a result consistent with the legislative intent.

CONCLUSION

The petition for writ of *certiorari* should be granted.

Respectfully submitted,

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The MARYLAND PSYCHIATRIC SOCIETY, INCORPORATED, a District Branch of the American Psychiatric Association, Plaintiff-Appellee

v.

Martin P. WASSERMAN, M.D., J.D., Secretary, Department of Health and Mental Hygiene of the State of Maryland, Defendant Appellee,

and

Donna E. Shalala, Secretary of Health and Human Services, Defendant.

The MARYLAND PSYCHIATRIC SOCIETY, INCORPORATED, a District Branch of the American Psychiatric Association, Plaintiff-Appellee

v.

Donna E. SHALALA, Secretary of Health and Human Services, Defendant-

Appellant,

and

Martin P. Wasserman, M.D., J.D.,
Secretary,
Department of Health and Mental
Hygiene of the State of Maryland,
Defendant.

Nos. 95-2767, 95-2970.

United States Court of Appeals,
Fourth Circuit.

Argued Oct. 31, 1996.

Decided Dec. 16, 1996.

OPINION

WILKINSON, Chief Judge:

The Maryland Psychiatric Society, a professional association of psychiatrists, seeks injunctive and declaratory relief against Donna Shalala, Secretary of Health and Human Services, and Martin

Wasserman, Secretary of the Maryland Department of Health and Mental Hygiene. The Society challenges the Secretaries' interpretation of the federal statutes governing payments for

out-patient psychiatric services under a joint Medicare/Medicaid program called the Qualified Medicare Beneficiary ("QMB") Program. The district court agreed with the Society's interpretation and granted summary judgment in its favor. Because the district court's ruling imposes a financial burden on states which finds no basis in the relevant Medicare and Medicaid statutes, we reverse its judgment.

I.

The QMB program, thoroughly described in *Rehabilitation Ass'n of Va.*,

Inc. v. Kozlowski, 42 F.3d 1444 (4th Cir. 1994),
is a hybrid of the Medicare and Medicaid programs. Individuals eligible for the program ("QMBs") have a certain percentage of their medical costs paid by Medicare (usually 80%). The remaining 20%, plus their annual premiums and annual deductibles, are paid by the state Medicaid

program. The Medicaid statute forbids charges to the QMBs themselves over a nominal amount. 42 U.S.C. §1396o.

Unlike most services where Medicare
pays 80% of the full fee schedule amount, outpatient psychiatric services are only partially covered. Medicare coverage for these services is first calculated by excluding

37.5% from the fee schedule amount, and then paying 80% of the remaining 62.5%. 42 U.S.C. §§1395*l*(c), 1395*l*(a).

At issue in this case is who pays the excluded 37.5% for patients covered by the QMB program. The state of Maryland has paid the 20% of the 62.5% for QMBs under the state Medicaid program. The question of who pays the 37.5% exclusion, however, is not addressed in either the Medicaid or the Medicare Statutes. Maryland's Secretary of Health and Mental Hygiene has taken the position that Maryland is not responsible for

covering it. The United States supports this view. The Society argues on the other hand
that the QMB statute requires the states to pay for the exclusion.

The District Court granted the

Society's motion for summary judgment, ruling that the Society had the better view of the applicable statutory provisions. Secretaries Wasserman[1] and Shalala both

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[1] Secretary Wasserman raises two preliminary challenges on this appeal. He first argues that the Society lacks standing to enforce the provisions of Medicare and Medicaid because the intended beneficiaries of these statutes are patients, not psychiatrists, physicians or providers. We ruled to the contrary in *Rehabilitation Ass'n of Virginia v. Kozlowski*, 42 F.3d 1444 (4th Cir. 1994). Wasserman next contends that under *Seminole Tribe of Florida v. Florida*, ____U.S.____, 116 S.Ct. 1114, 134 L.Ed.2d 252 (1996), this Court lacks jurisdiction to hear the Society's claim against him. He argues that because the Medicaid Act has a "comprehensive and detailed remedial scheme", Congress must have intended to foreclose suits designed to force state officials to comply with the terms of the Act. The Supreme Court rejected virtually identical arguments in *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990), ruling that the federal Secretary's "generalized powers" to audit and sanction noncompliant states "were insufficient to foreclose reliance on §1983 to vindicate federal rights" in the Medicaid Act. *Id.* at 522, 110 S.Ct. at 2524.

appealed.

II.

[1] A state must agree to pay for "medicare cost sharing" for QMBs in order to receive federal funds for its Medicaid program. 42 U.S.C. §1396a(a)(10)(E)(I). The term "medicare cost sharing" includes four specifically defined categories of costs that the state Medicaid program must pick up: premiums, coinsurance, deductibles, and the
20% left over after Medicare pays 80% for certain services. 42 U.S.C. §1396d(p)(3). Nowhere do the QMB provisions mention Medicare's 37.5% exclusion for outpatient psychiatric services. The Society urges this court to find that the 37.5% exclusion is implicitly included in the "coinsurance"

expenses that states are required to cover.

42 U.S.C. §1396d(p)(3)(B). This we cannot do. Such a reading of "coinsurance" violates the boundaries of federal power set forth in *Pennhurst v. Halderman*, 451 U.S. 1, 101 S.Ct. 1531, 67 L.Ed.2d 694 (1981), and finds no basis in the Medicare/Medicaid statutes.

A.

[2] By virtue of its spending power, Congress is permitted to condition receipt of federal funds upon certain state actions. *King v. Smith*, 392 U.S. 309, 333, 88 S.Ct. 2128, 2141, 20 L.Ed.2d 1118 (1968). Such conditions, however, must be explicit and unambiguous, so that states understand the bargain they have made when they sign up for federal programs. *Pennhurst*, 451 U.S. at 17, 101 S.Ct. at 1539-40. Moreover, "in those instances where Congress has intended the States to fund certain entitlements as a condition of receiving

federal funds, it has

proved capable of saying so explicitly."
Id.
at 17-18, 101 S.Ct. at 1540.

If Congress intended states to pay the 37.5% exclusion for outpatient psychiatric services for QMBs, it certainly did not say so explicitly, clearly, and unambiguously. The QMB provisions do not mention the exclusion at all. *See* 42 U.S.C. §1396a(a)(10(E)(I); 42 U.S.C. §1396d(p). While the Medicare statute allows non-QMB patients themselves to be charged the 37.5% excluded amount, 42 U.S.C. §1395cc(a)(2)(A), nothing in the statute mentions who, if anyone, is required to pay the excluded amount for QMB patients. *See* 42 U.S.C. §1395*l*(c).

The Society argues that states must cover the 37.5% exclusion because it is

included in the QMB provision requiring states to pay "[c]oinsurance under subchapter XVIII [the Medicare Act](including

coinsurance described in section 1395e of this title.)" 42 U.S.C. §1396d(p)(3)(B). The district court so found by looking to Webster's Ninth New Collegiate Dictionary to illuminate Congress's intention for the word "coinsurance". The court found that coinsurance means "a shared obligation or 'joint assumption of risk'" and that the 37.5% exclusion falls within this definition and should therefore be paid by the states for QMB patients.

[3] The problem with adopting the district court's definition of coinsurance is that it sweeps in too much and renders other provisions of section 1396d(p)(3)

superfluous. If the term coinsurance in section 1396d(p)(3)(B) were intended to include every payment obligation shared by the federal government and a state Medicaid program, then it would certainly encompass the 20% copayment required of states under the QMB program. If that were true, Congress would not have needed to include section 1396d(p)(3)(D), which requires the states to pay the 20% copayment for QMBs. Rules of statutory construction forbid us to construe one provision in a way that renders another provision of the same enactment superfluous. *Freytag v. Commissioner of Internal Revenue*, 510 U.S. 868, 877, 111 S.Ct. 2631, 2638, 115 L.Ed.2d 764 (1991).

[4] In all events, the general

dictionary definition of coinsurance is too loose to support the imposition of substantial financial burdens on state governments. Instead, we read the word "coinsurance" to refer specifically to those expenses that
Congress identified as "coinsurance" in the
statutory sections that 1396d(p)(3)(B) references. Such a reading of the word "coinsurance" is consistent with the text and structure of the statute. Section

1396d(p)(3)(B) requires states to pay QMB' "[c]oinsurance under subchapter XVIII [the Medicare Act] (including coinsurance described in section 1395e of this title.)" Section 1395e, describing cost-splitting for inpatient hospital services, explicitly uses the label "coinsurance" for certain identified costs not covered by

Medicare. Similarly, when Congress added new provisions to the Medicare Act to cover prescription drugs in 1988, it expressly called certain of the noncovered amounts "coinsurance". *See* Medicare Catastrophic Coverage Act of 1988. Pub.L. No. 100-360, Title III, §202, 102 Stat. 683, 702 (since repealed).

The 37.5% exclusion for outpatient psychiatric services, however, is not labeled as "coinsurance" anywhere in the Medicare or Medicaid statutes. Unlike the 1988 prescription drug obligations, the 37.5% amount is not called coinsurance in the

provision that excludes that amount from Medicare reimbursement. 42 U.S.C. §1395*l*(c). Nor does section 1396d(p)(3)(B) explicitly cross-reference or include the 37.5% exclusion in its terms.

Because no provision in either the Medicare or Medicaid statutes explicitly and unambiguously requires states to cover the 37.5% exclusion, reading the QMB statute to mandate state coverage imposes a burden in violation of *Pennhurst*. As the Supreme Court has explained,

> The case for inferring intent is at its weakest where, as here, the rights asserted impose affirmative obligations on the States to fund certain services, since we may assume that Congress will not implicitly attempt to impose massive financial obligations on the States.

Pennhurst, 451 U.S. at 16-17, 101 S.Ct. at 1539. The states signed up to pay

narrowly-defined categories of premiums, coinsurance, deductibles and 20% of the incurred expenses for specific services. Nowhere did there contract with the federal government say that states would be required to cover amounts that were totally excluded from the Medicare calculation. Nowhere did their contract even suggest that the states must pick up 50% of the tab for any medical service (the 37.5% exclusion plus 20% of the remaining 62.5% equals 50% of total cost.) *Pennhurst* does not permit the federal courts

to connive in this sort of ambush of state treasuries. Redrafting the terms of understandings between the state and federal governments is little different from renegotiating contracts between private parties. Both are impermissible.

B.

The impropriety of imposing the 37.5% exclusion on states is underscored by several other factors. Among them is the fact that the federal Secretary of Health and Human Services, who is responsible for administering the QMB program, agrees that the states are not responsible for paying the 37.5%. It would take an extraordinary view

of *Pennhurst* and *Chevron v. Natural Resources*, 467 U.S. 837, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984), to fasten large financial burdens on the states in violation of the statutory interpretation of the federal implementing agency.

It is true that the Secretary espoused a contrary interpretation prior to 1992, and that her current interpretation of the statute may thus be entitled to less deference. *See INS v. Cardoza-Fonseca*, 480 U.S. 421, 446 n. 30, 107 S.Ct. 1207, 1221 n. 30, 94 L.Ed.2d 434 (1987). Even so, we find it to be significant that the

federal Secretary and the state Secretary are in accord. If the state and

federal governments both believe that they agreed to the same terms in their QMB contract, courts should not casually change those terms and require the states to spend millions of dollars on psychiatric services.

The state's interpretation of the statute is also bolstered by the fact that the Society's arguments rest on a faulty assumption. The Society asserts that its member psychiatrists possess a statutory right to recover 100% of their reasonable

charges in all circumstances, and that therefore some government entity, either state or federal, must pay the exclusion. *See New York City Health & Hosps. Corp. v. Perales*, 954 F.2d

854, 858 (2d Cir. 1992)(finding that Part B providers have an "express statutory right to recover their full reasonable costs and charges.")

[5] The Society's assumption has no basis in the statute. While 42 U.S.C. §1395cc(a)(2)(A) authorizes providers to charge for the full amount of provided services, it does not guarantee

full recovery. In *Rehabilitation Association*, this court declined to rest its judgment on a statutory right to 100% recovery for Medicare Part B providers, despite the fact that the district court had ruled on precisely that ground. Further, section

1395cc(a)(2)(A) applies only to "providers of services". "Providers of services" is a term of art which includes hospitals, nursing homes, clinics and similar organizations. It does not include physicians. 42 U.S.C. §§1395x(u), 1395cc(e). To the extent that the Society's case rests on the premise of a

100% recovery guarantee to plaintiffs in all circumstances based on the Medicare or Medicaid statutes, we find it flawed.

Finally, the state's interpretation of the statute complies with Congress' judgment that mental health services have a lesser claim than physical health services on scarce governmental resources. For most outpatient physical health services, Congress has provided that Medicare will cover 80% of the reasonable cost. 42 U.S.C. §1395*l*(a). By contrast, Medicare covers only 50% of outpatient mental health services (80% of 62.5%). 42 U.S.C. §1395*l*(c). It would be ironic to conclude that when Congress

designates a particular service for lesser funding it expects states to spend a greater percentage of their limited Medicaid funds on that disfavored service. As the Supreme Court has noted:

> Title XIX [Medicaid] was designed as a cooperative program of shared financial responsibility, not as a device for the Federal Government to compel a State to provide services that Congress itself is unwilling to

fund.

Harris v. McRae, 448 U.S. 297, 309, 100 S.Ct. 2671, 2684, 65 L.Ed.2d 784 (1980). Congress could not have intended to leave the states holding the bag on every congressional exclusion. We certainly find no such obligation in the instant case.

III.

For the foregoing reasons, we reverse the judgment of the district court and remand this case with directions that it be dismissed.

REVERSED.

UNITED STATES COURT OF

APPEALS

FOR THE FOURTH CIRCUIT

FILED February 11, 1997

No. 95-2767

C-A-95-894-3

THE MARYLAND PSYCHIATRIC SOCIETY,

INCORPORATFD, a District Branch of

the

American Psychiatric Aasociation

Plaintiff - Appellee

v.

MARTIN P. WASSERMAN, M.D., J.D.,

Secretary, Department of Health and

Mental Hygiene of the State of

Maryland

Defendant - Appellant

and

DONNA E. SHALALA, SECRETARY
OF HEALTH AND HUMAN SERVICES

Defendant

No. 95-2970

CA-95-894-S

THE MARYLAND PSYCHIATRIC
SOCIETY,
INCORPORATED, a District Branch of
the
American Psychiatric Association

Plaintiff - Appellee

v.

DONNA E. SHALALA, SECRETARY
OF HEALTH AND HUMAN SERVICES

Defendant - Appellant

and

MARTIN P. WASSERMAN, M.D., J.D.,
Secretary, Department of Health and
Mental Hygiene of the State of Maryland

Defendant

On Petition for Rehearing with Suggestion for Rehearing in Banc

The appellee's petition for rehearing and suggestion for rehearing in banc were submitted to this Court. As no member of this Couit or the panel requested a poll on the suggestion for rehearing in banc, and

As the panel considered the petition for rehearing and is ofthe opinion that it should be denied,

IT IS ORDERED that the petition for rehearing and suggestion for rehearing in banc are denied.

For the Court,

/s/ Patricia S. Connor

CLERK

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

The Maryland Psychiatric Society, Inc.,

Plaintiff

Civil No. S 95-894

v.

Donna Shalala, Secretary of Health and Human Services, et al.,

Defendants

MEMORANDUM OPINION

The Plaintiff in this case is a non-profit organization whose members provide psychiatric services to patients in the State of Maryland. The Defendants are the State and Federal government agencies involved in administering Medicare, Medicaid and the State of Maryland's medical assistance program. This case is before the Court on several motions, all of which will be addressed in the following opinion. The Plaintiff, Maryland Psychiatric Society, Incorporated, has filed both a Motion for a Preliminary Injunction and a Motion for Summary Judgment. Defendant Donna Shalala, Secretary of the Department of Health and Human Services ("Federal Defendant"), has responded to the Plaintiff's motions and filed a Motion to Dismiss and a Cross-Motion for Summary Judgment. In

addition, Defendant Martin Wasserman, Secretary of the Department of

Health and Mental Hygiene of the State of Maryland ("State Defendant"), has also opposed the Plaintiff's motions and filed a separate Motion to Dismiss and Cross-Motion for Summary Judgment. All of these motions address the validity of the Defendants' interpretation of certain provisions of the Medicare and Medicaid Acts which impact the reimbursement that Plaintiff's members receive for the provision of psychiatric services to a particular class of Medicare beneficiaries. The issues have been thoroughly briefed, and no oral hearing is necessary. D. Md. R. 105.6.

I. Facts

Congress enacted the Medicare Program in 1965 as Title XVIII of the

Social Security Act, 42 U.S.C. §§ 1395-1395ccc, to ensure access to quality medical care for elderly and disabled persons. Medicare is a federal health insurance program composed

of two parts, Part A and Part B. Part A covers in-patient hospital costs, 42 U.S.C. §§ 1395c - 1395i-4, and Part B covers physician services and hospital outpatient services. 42 U.S.C. §§ 1395J - 1395w-4. Enrollment in Part A is essentially automatic when a person becomes eligible for Social Security benefits. Rehabilitation Ass'n of Virginia, Inc. v. Kozlowski, 42 F.3d 1444, 1446 (4th Cir. 1994), petition for cert. filed, 63 U.S.L.W. 38949 (May 27, 1995) (No. 94- 1912). In contrast, Part B is a voluntary, supplemental insurance program available to those persons eligible to receive

Medicare Part A benefits. 42 U.S.C. §§ 1395j - 1395w-4. The issues in this case relate to reimbursement for outpatient psychiatric services, which are covered under Medicare Part B.

Medicare-eligible individuals who choose to enroll in Part B are responsible for an monthly enrollment premium and an

annual deductible for covered services. The government also sets a fee schedule for covered services, sometimes referred to as the "reasonable charge." Af ter the deductible has been met, the federal government reimburses the provider of the services for 80% of the fee schedule amount. 42 U.S.C. S 13951(a)(1). Typically, the beneficiary is responsible for the remaining 20% of the fee schedule amount. 42 U.S.C. §§ 13951(a) (1),

1395w-4(a) (1) . The 20% which the beneficiary must pay is usually referred to as a copayment or coinsurance. Rehabilitation Ass'n, 42 F.3d at 1446; e.g., 42 C.F.R. § 410.3(b) (1994) ("The beneficiary is responsible for an annual deductible and . . . for coinsurance amounts specified for most of the services.) The Medicare Part B statute, however, does not explicitly label it as such. In this way, the Medicare program is financed wholly by the

federal government and the individual beneficiaries.

Also established in 1965, the Medicaid program, Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396v, aims to provide medical assistance to needy individuals and families. Unlike Medicare, Medicaid is a

joint federal-state program. 42 U.S.C. § 1396b(a) (1), 1396d(b). States are not required to participate in the Medicaid program. If they elect to do so, they must follow federal guidelines and submit a medical assistance plan (MAP) to federal authorities for approval in order to receive matching funds. 42 U.S.C. § 1396a(b). States develop their own schedules for the fees which the state will pay physicians for services covered by the plan. Rehabilitation Ass'n, 42 F.3d at 1447. These state schedules are typically much lower than the fee schedule set by the federal government

under the Medicare program. Id. Physicians who participate in the Medicaid program cannot accept payment in excess of the rates established by the state. 42 U.S.C. § 1320a-7b(d). In other words, they

cannot
attempt to collect any additional amounts from their Medicaid patients.

The Qualified Medicare Beneficiary (QMB) , or "Buy-in," program is intended to help elderly or disabled persons who are also impoverished, and thus represents a hybrid of the Medicare and Medicaid programs. As discussed, Medicare beneficiaries are responsible for substantial premiums, deductibles and copayments under that program. The QMB program was designed to provide access to high quality health care for Medicare recipients unable to afford these costs of participating in Medicare. Omnibus Budget Reconciliation Act of 1986, H.R. No. 727, 99th, Cong., 2d Sess. 102-06, reprinted

in 1986 U.S.C.C.A.N. 3607, 3692-96.

Generally, people who are eligible to receive Medicare, and whose income falls below the federal poverty line, are eligible to participate in the QMB program. 42 U.S.C. § 1396d(p)(1). Under this program, the state medical assistance program, established pursuant to the Medicaid statute, pays the qualified medicare beneficiaries' (QMBs') Medicare cost-sharing obligations. 42 U.S.C. § 1396a(a)(10)(E). Physicians treating QMBs must, in Medicare parlance, "accept assigrment;" in other words, they must accept the federal and state payments as full satisfaction of their bill and cannot charge the QMB patient any additional amount. 42 U.S.C. § 1395w-4(g)(3)(A).

As the Fourth Circuit explained in the Rehabilitation Association decision, the QMB program is a "real deal" for the

states, in that many QMBs are eligible for Medicaid as

well as Medicare, and if these QMBs could not participate in Medicare, the state Medicaid program would be left with primary responsibility for their medical expenses. 42 F.3d at 1448. Under the QMB program, however, the federal government's Medicare program pays the bulk of the QMB's expenses, and the state uses its Medicaid dollars (some of which are federal in origin) to pay only the medicare premiums, deductible and copayments. In this way, the states essentially "buy in" their QMBs to the Medicare program.

The issue in this case involves the State of Maryland's obligation under the QMB program to pay the Medicare cost-sharing amounts for outpatient

psychological services available under Medicare Part B. As discussed, under the QMB program, the State's medical assistance program pays a QMB's Medicare premiums,

deductible, and coinsurance. The amount of coinsurance is usually 20% of the Medicare fee schedule amount, because the federal government usually pays 80% of the fee schedule amount pursuant to section 13951(a)(1). With regard to mental health services, however, the Medicare Part B statute includes a special provision, which is central to this dispute. It provides:

> . . . [W]ith respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and

> personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as. incurred expenses for purposes of subsections (a) and (b) of this section only 62 and 1/2 percent of such expenses . . . . 42 U.S.C. S 13951(c).

It is undisputed that this section operates to make the federal government responsible for only 80% of 62.5% of the fee schedule amount for mental health services, an amount which equates to 50% of the total fee schedule amount (.80 x .625 = .50). It is also undisputed that, for QMBS, the State of Maryland's medical assistance program is responsible for at

least the remaining 20% of the 62.5% of the fee schedule amount, which is 12.5% of the total fee schedule amount (.20 x .625 = .125). Finally, the Medicare statute allows a provider of mental health services to charge the beneficiary "or other person" for the remaining 37.5% of the fee schedule amount. 42 U.S.C. § 1395cc(a)(2)(A).

The following example may clarify this scheme. If a physician performed services for which the Medicare fee schedule amount was $100.00, he ordinarily would receive $80.00 from the federal government (assuming the yearly deductible had been exhausted) and could collect $20.00 from the Medicare beneficiary. In the case of a QMB, that $20.00 would be paid by the State. In contrast, a provider of mental

health services could collect only $50.00 from the federal Medicare program (an amount equal to 80% of 62.5% of the $100.00 fee schedule amount). The mental health service provider could look to the beneficiary for the remaining $50.00 of the fee schedule amounti unless the beneficiary was a QMB. In the case of a QMB, the state would pay 20% of. the 62.5% of the $100.00 fee schedule amount, which equals $12.50 in this example.

Thus, the central question in this case

appears. In the above example, the mental health provider has "come up short" by $37.50, as Medicare paid $50.00 and the state paid $12.50. This case concerns who must account for the shortfall.

There is no authority for imposing on the federal government an obligation greater than 80% of 62.5% of the fee

schedule amount. In addition, both federal and state authorities prohibit doctors ffrom charging the QMB for this amount. See 42 U.S.C. § 1395w-4(g)(3)(B); Md. Regs. Code tit. 10, § 09.36.03(6). Therefore, either the State must pay the remaing 37.5%, or the providers themselves must absorb the loss. The Plaintiff maintains that the 37.5% represents an additional copayment, and that the State is responsible for paying this amount on behalf of its QMBS. Conversely, the Defendants argue that no one is required to reimburse the providers of mental health services for

this amount and that the providers must absorb the loss themselves when they treat QMBS.

The Department of Health and Human Services has taken inconsistent

positions on this issue. In 1989, in response to an inquiry from the State of Missouri, the Department issued an opinion which provided that

> [w]hile the 37.5 percent of approved charges referred to is not usually called a coinsurance in Medicare administrative issuances, that is what it, in fact, is. Therefore, the State is responsible for 37.5 percent of the approved charges, plus 20 percent of the remainder of those charges, for outpatient psychiatric services, in the situation described.

Memorandum from Kathleen A. Buto,

> Acting Director, Bureau of Eligibilityr Reimbursement and Coverage, Exhibit 1, Memoranum of Law in Support of Plaintiff's Motion for Summary Judgment, ¶ 3

(emphasis added).

In 1992, however, a superseding memorandum was issued in response to an inquiry from the State of Georgia, which opined that

> (t)he remainder following the 62 and 1/2 percent reduction is not labeled coinsurance under the statute, regulations, or section 2170 of the Medicare Carriers Manual. Therefore, Medicaid will not recruire States to pay toward the 37 and 1/2 percentage which is excluded from incurred cost as a coinsurance amount. Memorandum from Christine Nye, Director, Medicaid Bureau, Exhibit 2,

Memorandum of Law in Support of Plaintiff's Motion for Summary Judgment, ¶¶ 6-7 (emphasis added).

The Court must now resolve the conflict between these two positions.

II. Legal Standard

Under Rule 12(b)(6) of the Federal Rules of Civil Procedure, the Court may dismiss an action for failure to state a claim upon which relief can be granted. When reviewing a claim pursuant to a Motion to Dismiss, the Court must presume all factual allegations of the complaint to be true. Miree v. De Kalb County, 433 U.S. 25 (1977). However, legal conclusions or deductions, framed as factual allegations, do not benefit from a presumption of truthfulness. United States v. Tulare Lake

Canal Co., 535 F.2d 1093, 1097 (9th Cir. 1976), cert. denied, 429 U.S. 1121 (1977). Dismissal is not warranted unless "it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief." Conley v. Gibson, 355 U.S. 41, 45-46 (1957) (citations omitted).

Summary judgment is appropriate when the moving party demonstrates through "pleadings, depositions, answers to interrogatories, admissions on file, and affidavits, if any, that no genuine issue of material fact exists and that the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c) . A fact is material only if, when applied to the substantive law, the fact affects the outcome of the suit. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248 (1986).

The material facts in this case are

undisputed, and only a pure question of law is presented. In light of the above standards and for the reasons explained below, the Plaintiff's Motion for Summary Judgment will be granted, and the Defendants' motions will be denied.

III. Analysis

As the Fourth Circuit noted in its important decision, Rehabilitation Ass'n of Virginia, Inc. v. Kozlowski, 42 F.3d 1444, the statutes involved in this case, involving the financing of Medicare and Medicaid, "are among the most completely impenetrable texts within the human experience." Id. at 1450. And like the Fourth Circuit, this Court also "approaches them at the level of specificity herein demanded with dread, for . . . they [are] dense reading of the most tortuous kind."

A. Deference to the Agency's Interpretation

The Defendants argue that in light of this complexity, the Court should defer to the interpretation of the goverrment agency charged with administering the Medicare and Medicaid programs, the Department of Health and Human Services. In general, deference to the expertise of an administrative agency is appropriate when the language of the statute is ambiguous. Chevron U.S.A., Inc. v. Natural Resources Def ense Council, Inc, 467 U.S. 837, 844 (1984). A complex statute, however, is not the same thing as an ambiguous one. New York City Health and Hospitals Co v. Perales, 954 F.2d854, 862 (2nd Cir.), cert. denied, _ U.S._, 113 S.Ct. 461 (1992). "If a court, employing traditional tools of statutory construction, ascertains that Congress has an intention on the precise question at issue, that intention is the law

and must be given effect." Chevron, 467 U.S. at 843 n.9.

Moreover, far less deference is warranted when the administrative agency's interpretation of the statute at issue has been inconsistent. Immigration and Naturalization Serv. v. Cardoza-Fonseca, 480 U.S. 421, 446 n.30 (1987) ("An agency interpretation of a relevant provision which conflicts with the agency's earlier interpretation is entitled to considerably less deference than a consistently held agency view.") (internal citations omitted); Samaritan Health Serv. v. Bowen, 811 F.2d 1524, 1529 (D.C. Cir. 1987). As the Second Circuit has noted, "The expertise in statutory interpretation to which we normally defer becomes dubious when the expert cannot. make up its own mind." Perales, 954 F.2d at

861-62. Because the Court determines that Congress has expressed its intent on the issues in this case, and because

the Department of Health and Human Services has espoused varying interpretations of the statutory provisions governing reimbursement for mental health services, no deference to the Department's current interpretation of the statute is warranted.

B. "Medicare Cost-Sharing" - Section 1396d(ip)(3)

This case presents a narrow issue of statutory interpretation. The provision at the heart of this dispute is section 1396d(p)(3) of Title 42 of the United State Code. This section details the states' responsibility for paying Medicare cost-sharing amounts for QMBS. It

provides

(3) The term "medicare cost sharing" means the following costs incurred with respect to a qualified medicare beneficiary . . .

(A) (i) premiums under section 1395i-2 or

1395i-2a of this title, and

(ii) premiums under section 1395r of this title,

(B) Coinsurance under subchapter XVIII of this chapter (including coinsurance described in section 1395e of this title)

(C) Deductibles established under subchapter XVIII of this chapter (including those described in

section 1395e and section 13951(b) of this title)

(D) The difference between the amount that is paid under section 13951(a) of this title and the amount that would be paid under such section if any reference to "80 percent" therein were deemed a reference to "100 percent".

42 U.S.C. § 1396d(p)(3). The key question then is whether the 37.5% of the fee schedule amount for mental health services, which the federal Medicare program does not pay pursuant to section 13951(c), fits within any of the four section 1396d(p)(3) categories of "Medicare cost-sharing," which the states are obligated to pay in the case of QMBS.

It is undisputed that the 37.5% amount is not a premium within the

meaning
of subsection (A) or a deductible within the meaning of subsection (C) of section 1396d(p)(3). The real issue is whether the amount falls within subsections (B) or (D). If so, then the State of Maryland is responsible for reimbursing providers of mental health services for this amount; if not, then these providers must absorb the loss

themselves.

1. Subsection D

The disputed percentage does not fit comfortably within the language of subsection (D). As explained above, Medicare patients are typically billed for physician services at the rate of 20% of the fee schedule amount. With respect to mental health services and the limitation on Medicare reimbursement found in

section 13951(c), the Medicare statute explicitly provides that doctors may bill Medicare patients for the full 50% amount that the federal government does not pay. 42 U.S.C.S 1§ 1395cc (a) (2) (A) (In the case of items and services described in section 13951(c) of this title, [a provider may determine the
amount to bill the recipient of theservices] by substituting for 20% the proportion which is appropriate under such section.")

In section 1395cc(a)(2)(A) at least,

Congress explicitly noted that the Medicare patient's cost-sharing responsibilities, which normally include only 20% of the fee schedule amount, in the case of mental health services may include a larger percentage of the fee schedule amount.

Section 1396d(p) (3) (D), however, contains no such proviso and defines as "Medicare cost-sharing" as the difference between 80% and 100%, making no mention of the fact that in the case of mental health services, the normal 80% figure effectively is reduced to 50%. The Plaintiff urges the Court to read subsection D broadly to imply a similar intent to make exception for the 50% mental health coinsurance amount. In light of the unambiguous statutory language, the Court declines to do so. 80% means 80%, and there is nothing vague about it. Nevertheless, this conclusion does not determine the outcome of this case because

section 1396d(p)(3)(B) encompasses by its own terms the 50% coinsurance amount.

2. Subsection B

Subsection B refers to "Coinsurance under subchapter XVIII of this chapter." It is a well-known principle of statutory construction that "words should be given their common and approved usage, " unless "it is obvious from the act itself that the legislature intended that [the word] be used in a sense different from its common meaning." 2A Norman J. Singer, Sutherland Statutory Construction § 46.01, at 82, 83 (5th ed. 1992) [hereinafter Singer]. See also Palestine Info. Office v. Schultz, 853 F.2d 932, 937-38 (D.C. Cir. 1988). Coinsurance is not a defined term in the Medicare Part B statute; however, the statute's treatment of the 37.5% amount places it squarely within the ordinary concept of coinsurance as a shared obligation or joint assumption of

risk." Webster' s Ninth New Collectiate Dictionary 257 (1986). As explained above, the statute allows providers of mental health services to charge their non-QMB Medicare patients for this amount. 42 U.S.C. S 1395cc(a)(2)(A).

Moreover, legislative history repeatedly refers to the disputed amount as coinsurance. For example, in amending the mental health services provision in the Medicare Catastrophic Coverage Act of 1988, the Committee Report works through a numerical example and explains how Medicare pays only 80% of 62.5%, i.e., 50%, of the fee schedule amount and that therefore, "the effective coinsurance rate is 50 percent . . . H.R. Rep. No. 100-105(l), 100th Cong., 2d Sess., 24, reprinted in 1988 U.S.C.C.A.N. 803, 826 (emphasis added) . The Report goes on to note that the proposed amendment would

not affect these

calculations, stating that "[t]he coinsurance requirement would remain the same." Id. Similarly, the Conference Report notes that "the effective beneficiary coinsurance rate remains the same." H.R. Conf. Rep. No. 661, 100th Cong. , 2d Sess, 208, reprinted in, 1988 U.S.C.C.A.N. 923, 986. Congress again addressed the Medicare provisions pertaining to mental health services in the Budget Reconciliation Act of 1989. The legislative history explains that for mental health services, "[t]he patient is responsible for 50 percent coinsurance, instead of the standard 20 percent." H.R. Rep. No. 101-247, 101st Cong, lst Sess. . 361, reprinted in 1989 U.S.C.C.A.N. 1906f 2087. The Committee intended to "retain[] the 50

percent coinsurance." Id.

Although these comments are not conclusive evidence of legislative intent on the appropriate characterization of the 37.5%
amount, they nevertheless provide valuable guidance. Unlike the post-enactment legislative history rejected in the Rehabilitation Ass'n decision, the quoted coinsurance language does not "work a wrenching change to a statute's meaning which had been stable for 20 years," nor " contradict[ ] settled understanding of the statute's provisions." 42 F. 3d at 1457-58. The only settled understanding of the disputed amount regards the federal goverment's limited Medicare obligation to

pay only 80% of 62.5% of the fee schedule amount. As the Federal Defendant's own inconsistent position on the issue demonstrates, there has been no settled

understanding regarding the appropriate characterization of the 37.5% remainder. For this reason, the legislative history cited is a source of helpful insight.

Nor is it appropriate to ignore the legislative history's coinsurance language because it pertains to the mental health limitation itself, section 13951(c), rather than the general provision defining cost-sharing under the QMB program, section 1396d(p)(3). At issue is the characterization of the remainder excluded under section 13951(c). Legislative history which describes that remainder as a coinsurance amount or copayment is entirely relevant to the issue of whether the remainder is "coinsurance under subchapter XVIII" within the meaning of section 1396d(p)(3)(B). The QMB program is a hybrid of the Medicare and

Medicaid programs; therefore, the Medicare and Medicaid statutes must be read consistently. If the disputed amount is coinsurance under section 13951(c), then it is coinsurance under section 1396d(p)(3)(B).

Finally, the Defendants also argue that the coinsurance referred to in subsection B only includes amounts defined as coinsurance under Medicare Part A. Yet the plain language of the statute belies that interpretation. Subsection B refers to "Coinsurance under subchapter XVIII of this chapter (including coinsurance described in section 1395e of this title)." 42 U.S.C. § 1396d(p)(3)(B). "Subchapter XVIII" is the entire Medicare program -- not merely Part A. The statute's specific

citation of "Subchapter XVIII," rather than the Part A provisions, is highly significant.

The statute also refers to section 1395e. Section 1395e is within Part A, yet by the terms of the statute, coinsurance under subsection B only "includes" the coinsurance described in section 1395e. "[T]he word 'includes' is usually a term of enlargement, and not of limitation It, therefore, conveys

the conclusion that there are other items includable, though not specifically enumerated . . . ." Singer, § 47.07, at 152. In sum, the language of the statute does not support the Defendants' interpretation that the term "coinsurance" is limited to that coinsurance described in section 1395e or Part A. Instead,

cost-sharing is explicitly defined to include all coinsurance under Parts A and B of the Medicare program. The Court will not read into the statute a limitation which is refuted by the broader terms of the statute itself. U.S. v. Harvey, 814 F.2d 905, 916 (4th Cir. 1987) (citing Consumer Prod. Safety Comm'n v. GTE Sylvana Inc., 447 U.S. 102, 110-11 (1980)); In re Forfeiture Hearing as to Caplin & Drysdale, Chartered, 837 F.2d 637, 642 (4th Cir. 1988).

For all of these reasons, this Court agrees with the Department of Health and Human Services, first opinion regarding the disputed 37.5% -- that "coinsurance" "is what it, in fact, is." Memorandum from Kathleen A. Buto, Acting Director, Bureau of Eligibility, Reimbursement and Coverage,

Exhibit 1, Memorandum of Law in Support of Plaintiff's Motion for Silmmary Judgment, ¶ 3. The plain language of the statute, the legislative history, and the fact that the disputed amount has all the normal characteristics of coinsurance reinforce this conclusion. The Court finds that the 37.5% amount is included within the meaning of section 1396d(p)(3)(B) and thus qualifies as Medicare cost-sharing which the State is obligated to pay on behalf of its QMBS.

C. Case Law and the QMB Program

Four recent circuit court decisions, New York City Health and Hosp. Corp. v. Perales, 954 F.2d 854 (2nd Cir. 1992), Pennsylvania Medical Soc'y v. Snider, 29 F.3d 886 (3rd Cir. 1994), Rehabilitation Ass'n of Virginia, Inc. v. Kozlowski, 42

F.3d 1444 (4th Cir. 1994) . and Haynes Ambulance Serv. v. State of Alabama, 36 F.3d 1074 (llth Cir. 1994), which extensively discuss the QMB program, buttress the Court's conclusion that providers of mental health services are not required to absorb a 37.5% loss. In each of these cases, the panels faced the question of whether states were obligated under the QMB program to pay the entire 20% Medicare coinsurance on behalf of their QMBS, or whether they could cap that payment if the total amount charged by the provider exceeded the Medicaid fee schedule amount (which is usually substantially lower than the Medicare fee schedule amount). All four courts held that QMB patients were primarily Medicare patients, that providers were entitled to

receive the Medicare fee schedule amount, and that the states must pay the entire 20% copayment on behalf of their QMBs.[2]

In Perales, the Second Circuit flatly held that "Providers who furnish medical care to Medicare eligible patients have the right to collect 100 percent of their reasonable costs or charges. 954 F.2d at

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[1]The Plaintiff seems to challenge various Maryland regulations which allegedly permit the State to reimburse QMB providers at the Medicaid rate, in contravention of the holding in Rehabilitation Ass'n, 43 F.3d 1444. However, there is no allegation that these regulations have ever been enforced against the Plaintiff's members in this context, nor that there is any credible threat of enforcement. Moreover, there is no indication that these regulations played any role in the Defendants' interpretation of section 1396d(p)(3) or the State's practice of reimbursing providers of mental health services at the rate of 12.5 percent of the Medicaid fee schedule amount. This case presents a very narrow issue of statutory interpretation, to which the maryland regulations the Plaintiff cites do not speak. See supra, at 11-12. Thus, the Plaintiff's ill-formed challenge to these regulations does not present a live controversy ripe for judicial decision, and the Court will not consider it. See Renne v. Geary, 501 U.S. 312t 320-23 (1991).

858. Similarly, in Snider, the Third Circuit

added that "the Medicare Act contains no exception to the reimbursement of 100 percent of the reasonable costs and charges for QMBS. " 29 F. 3d at 891. The Fourth Circuit has stated its view that "Our reading of the statute, and the contemporaneous legislative history, discloses to us clear Congressional intent that state copayments under the buy-in program for [QMBS] be, except for optional nominal charges . . . , complete." Rehabilitation Ass'n, 42 F. 3d at 1458 (emphasis added). These authorities demonstrate the lack of support for the Defendants' position that providers must accept an amount substantially below the fee
schedule amount as full payment for their services in the case of QMBS. See

Perales, 954 F.2d at 860 ("a Medicare provider need not be satisfied with inadequate payment . . . even when that provider is treating a Medicare patient who happens also to be poor").

The QMB program "requires the states to pay any and all premiums, deductibles, and copayments for the elderly poor . . . ." Rehabilitation Ass'n, 43 F.3d at 1459 (emphasis added). This Court agrees with the Fourth Circuit that "It seems logical to simply see this [QMB program] as an instance where, because of the poverty of the QMB, the state, rather than the individual, shoulders payment for the cost-sharing provisions of the Medicare program." Id. It is as if the State Steps into the shoes of the QMB and assumes the QMB's Medicare obligations. Snider,

29 F.3d at 892. In the case of mental health services, these obligations simply happen to higher than the normal 20%.

The purpose of the QMB procjram was to "guarantee[] that indigency should not affect an individuals participation in the

Medicare Part B program." Rehabilitation Ass'n, 42 F.3d at 1459. This purpose would surely be undermined if providers of mental health services began avoiding treating the QMB population because of the inadequate payment they receive. In sum, the Court finds no direct support for the Defendants' position that Congress intended that providers of mental health services shoulder the financial burden of treating impoverished Medicare recipients. By contrast, the Fourth Circuit's guidance

in this area supports the opposite conclusion, that the State must assume complete responsibility for the Medicare obligations of QMBs.

IV. Conclusion

In light of the plain language of section 1396d(p)(3)(B), the relevant legislative history, and the broader policies behind the QMB program, the Court concludes that the 37.5% of the Medicare fee schedule amount which is not covered by Medicare under section 13951(c), is "Medicare cost sharing" within the meaning of section 1396d(p)(3). Accordingly, the Plaintiff's Motion for Summary Judgment will be granted. Both the Federal and State Defendants' Motions to Dismiss and Motions for Summary Judgment will be denied, and the Plaintiff's Motion for a Preliminary Injunction will be denied as moot. An

appropriate order will be entered separately and a permanent injunction will issue.

_____

_____

Frederic N. Smalkin
United States District Judge

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MARYLAND

The Maryland Psychiatric Society, Inc., *

Plaintiff *

Civil No. S 95-894

v. *

Donna Shalala, Secretary of Health and Human Services, et al., *

Defendants *

* * * * * * * * * * *

JUDGMENT ORDER AWARDING DECLARATORY AND INJUNCTIVE RELIEF

For the reasons given in the Court's

Memorandum Opinion filed herewith, it is hereby ADJUDGED and DECLARED that the 37.5% of the fee schedule amount which is excluded from Medicare coverage pursuant to 42 U.S.C. § 13951(c), is "Medicare cost sharing" within the meaning of 42 U.S.C. § 1396d(p)(3).

And it is hereby ORDERED that

1) The Motion f or Summary Judgment filed by the Plaintiff Maryland Psychiatric Society is GRANTED,

2) The Motion to Dismiss filed by the Defendant Donna Shalala, Secretary of Health and Human Services, is DENIED,

3) The Cross-Motion for Silmmary Judgment filed by the Defendant Donna Shalala, Secretary of Health and Human Services, is DENIED,

4) The Motion to Dismiss f iled by the Defendant Martin P. Wasserman, Secretary of the Maryland Department of

Health and Mental Hygiene, is DENIED,

5) The Cross-Motion for Summary Judgment filed by the Defendant Martin P. Wasserman, Secretary of the Maryland Department.of Health and Mental Hygiene, is DENIED,

6) The Motion for a Preliminary Injunction filed by the Plaintiff Maryland Psychiatric Society is DENIED as moot,

7) That the Clerk of the Court shall mail copies foregoing Memorandum opinion and Order to all parties. of the hereby

It is further ordered that the Defendants are hereby permanently RESTRAINED and ENJOINED from enforcing any policy or interpretation of 42

U.S.C. § 13951(c) and 42 U.S.C. § 1396d(p)(3) inconsistent with the terms of this order.

SO ORDERED, this 21st day of August, 1995.

Frederic N. Smalkin
United States District Judge

UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF WASHINGTON

AT SEATTLE

SOUTH SOUND RADIOLOGISTS, INC., et al

NO. C95-1218WD

Plaintiffs

v.

JEAN T. SOLIZ, et al

Defendants

* *

Plaintiffs have moved for a preliminary injunction or, in the

alternative, for summary judgment. The request for a

preliminary injunction has been dropped. The summary judgment motion has been fully briefed and argued; all materials filed, and the arguments of counsel given in open court on January 5, 1996, have been considered. Being fully advised, the court now finds and rules as follows:

1. The main issue in this case has been decided favorably to plaintiffs, position, and adversely to defendants' position, by all four federal circuits that have considered the matter to date. See Haynes Ambulance Service, Inc. v. Alabama, 36 F.3d 1074 (11th Cir. 1994); New York City Health and Hospitals Corp. v. Perales, 954 F.2d 854 (2d Cir.), cert. denied, 113 S. Ct. 461 (1992);

Pennsylvania Medical Society v. Snider, 29 F.3d 886 (3d Cir. 1994); Rehabilitation Ass'n of Virginia v. Kozlowski, 42 F.3d 1444 (4th Cir.), cert. denied, 116 S. Ct. 60 (1995). These cases are persuasive, although not binding, authority, and the court concludes that they were correctly decided.

2. As to plaintiffs' statutory claims, there is no genuine issue of material fact for trial, and plaintiffs are entitled as a matter of law to summary judgment under Fed. R. Civ. P. 56. This result must be ordered regardless of whether a de novo or deferential standard of review is applied, because it is required by the applicable federal statutes. Because the statutory claims are dispositive, plaintiffs' constitutional claims need not and will not be reached.

3. Under 42 U.S.C. §

1396(a)(10)(E)(I) and 1396d(p)(3), the State of Washington is obliged to pay the full and complete Medicare cost-sharing amounts, as defined at 42 U.S.C. § 1396d(p)(3), for Medicare Part B services provided to Qualified Medicare Beneficiaries ("QMBs"), as defined under federal law at 42 U.S.C. §

1396d(p)(1). The cost-sharing amounts include all amounts for which a Medicare beneficiary would be responsible if the beneficiary were not a QMB, including all coinsurance and deductible amounts.

4 . Under 42 U.S.C. § 1396d(p)(3), the State of Washington is obliged to pay the full and complete Medicare cost-sharing amounts for Medicare Part B outpatient mental health services provided to QMBS. The cost-sharing amounts include all amounts for which a

Medicare beneficiary
would be responsible if the beneficiary were not a QMB, including all coinsurance and deductible amounts. Coinsurance paid shall include both 37.5 percent of the Medicare allowed amount for outpatient mental health services and also 20 percent of 62.5 percent of the Medicare allowed amount.

5. The Department of Social and Health Services regulation which purports to
authorize the imposition of limits upon the State of Washington's payment of Medicare cost-sharing amounts for QMBS, WAC 388-87-011(l), is hereby declared invalid and unenforceable.

6. Defendant Soliz as Director of the Department of Social and Health Services of the State of Washington, and her successors, officers, agents, servants and employees, are permanently enjoined

from implementing or enforcing a policy of denying full and complete payment of Medicare cost-sharing amounts for Medicare Part B covered services, including outpatient mental health services, provided to QMBS

7. Defendant Soliz, and her successors, officers, agents, servants and employees in the said Department, shall make full and complete payment of Medicare cost-sharing amounts, for Part B services, including outpatient mental health services,

provided to QMBs for all claims for which a remittance advice has not issued as of the date of this order.

8. Plaintiffs have sought in this action, and could obtain, only prospective relief. Time is therefore of the essence if adequate relief is to be afforded. The

court finds that there is no just reason for delay and directs, pursuant to Fed. R. Civ. P. 54 (b) , that judgment be entered forthwith in accordance with this order.

9. Summary judgment motions in regard to all remaining claims or cross-claims that are now deemed ripe for summary judgment will be due on January 18, 1996. This date may be extended for good cause shown.

The clerk is directed to send copies of this order to all counsel of record.

Dated: January 8, 1996.

William L. Dwyer
United States District Judge

42 U.S.C. § 1396d(p)(3)

The term "medicare cost sharing" means the following costs incurred with respect to a qualified medicare beneficiary, without regard to whether the costs incurred were for items or services for which medical assistance is otherwise available under the plan:

A(I) premiums under 1395i-2 or 1395i-2a of this title, and

(ii) premiums under Section 1395s of this title,

B. Coinsurance under subchapter XVIII of this chapter (including coinsurance described in 1395e of this title).

C. Deductibles established under subchapter XVIII of this chapter (including those described in Section 1395e and Section

1395*l*(b) of this

title).

D. The difference between the amount that is paid under Section 1395*l*(a) of this title and the amount

that would be paid under such section if any reference to "80 percent" therein were deemed a reference to "100 percent". Such term may also include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary under Section 1395m of this title.

(Emphasis added.)

42 U.S.C. §1395u(b)(3)(B)

(3) Each such contract [between a participating physician or provider and the

Medicare carrier] shall provide that the carrier . . .

(B) will take such action as may be necessary to assure that, where payment is made under this part for a service on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier, and such payment will (except as otherwise provided in section 1395gg(f) of this title) be made -

(I) on the basis of an itemized bill; or

(ii) on the basis of an assignment under the terms of

which (I) the reasonable charge is the full charge for the service, (II) the physician or other person furnishing such service agrees not to charge (and to refund amounts already collected) for such service if payment may not be made therefore by reason of paragraph 1 of section 1395y(a) of this title . . . .

42 U.S.C. §1395u(b)(8) (A) and (B)(I)(ii)

(8)(A) The Secretary by regulation shall -

(I) describe the factors to be used in determining the cases (of particular items or services) in which the application of this subsection results in the determination of a reasonable charge that, by reason of a grossly excessive or grossly deficient amount, is not inherently reasonable, and

(ii) provide in those cases for the factors that will be considered in establishing a reasonable charge that is realistic and equitable.

(B)(I) The Secretary may provide for an increase or decrease in the

reasonable charge otherwise

recognized under this section with respect to a specific physicians' service only in accordance with the criteria set forth subparagraph (A) and with the following provisions of this paragraph.

(ii) The factors described pursuant to subparagraph (A)(I) with respect to payment for physicians' services shall include, but need not be limited to, the following:

(I) Prevailing charges for a service in a particular locality are significantly in excess of or below prevailing charges in other comparable localities, taking into account the relative costs of furnishing the services in the

different localities.

(II) The programs established under this subchapter and

subchapter XIX of this chapter are the sole or primary sources of payment for a service.

(III) The marketplace for a service is not truly competitive because of a limited number of physicians who perform that service.

(IV) There have been increases in charges for a service that cannot be explained by inflation or technology.

(V) The charges do not reflect changing technology,

increased facility with that technology, or reductions in acquisition or production costs.

(VI) The prevailing charges for a service under this part

are substantially higher or lower than the payments made for the service by other purchasers in the same locality.

42 U.S.C. §1395u(b)(18)(B)

(B) A practitioner describe in subparagraph (C) or any other person may not bill (or collect any amount from) the individual or other person described in subparagraph (A), except for deductible and coinsurance amounts applicable under this part. No person is liable for payment of any amounts billed for such a service in violation of the previous sentence. If a practitioner or other person knowingly and willfully bills (or collects an amount) for such a service in violation of such sentence, the secretary may apply sanctions against a physician in accordance with subsection (j)(2) of this section in the same manner as such section applies with respect to

a physician. Paragraph (4) of subsection (j) of this section shall apply in this subparagraph in the same manner as such paragraph applies to such section.

42 U.S.C. §1395u(b)(12)(C)[repealed]

(C) Except for deductible and coinsurance amounts applicable under section 1395*l* of this title, any person who knowingly and willfully presents, or causes to be presented, to any individual enrolled under this part a bill or request for payment of services described in clauses (I)(ii), or (iv) of section 1395x(s)(2)(K) of this title in violation of subparagraph (A)(I) is subject to a civil money penalty not to exceed $2,000 for each such bill or request. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding

under section 1320a-7a of this title.

42 U.S.C. §u(h)(1) and (7)

(1) Any physician or supplier may voluntarily enter into an agreement with the Secretary to become a participating physician or supplier. For purposes of this section, the term "participating physician or supplier" means a physician or supplier (excluding any provider of services) who, before the beginning of any year beginning with 1984, enters into an agreement with the Secretary which provides that such physician or supplier will accept payment under this part on an assignment-related basis for all items and services furnished to individuals enrolled under this part during such year. . . .

(7) The Secretary shall provide that each explanation of benefits

provided under this part for services furnished

in the United States, in conjunction with the payment of claims under 1395*l*(a)(1) of this title (made other than on an assignment-related basis),
shall include -

(A) a prominent reminder of the participating physician and supplier program established under this subsection (including the limitation on charges that may be imposed by such physicians and suppliers and a clear statement of any amounts charged for the particular items or services on the claim involved above

the amount recognized in
this part),
(B) the toll-free telephone
number or numbers,
maintained under paragraph

(2), at which an individual
enrolled under this part may
obtain information on
participating physicians and
suppliers,
(C)(I) an offer of assistance
to such an individual in
obtaining the names of
participating
physicians of appropriate
specialty and (ii) an offer to
provide a free copy of the
participating physician
directory, and
(ii) in the case of services for

which the billed amounts exceed the limiting charge imposed under section 1395w-4(g) of this title, information regarding such applicable limiting charge (including information on the right to a

refund under section 1395w-4(g)(1)(A)(iv) of this title).

42 U.S.C. §1395u(l)

(l) Definitions

For purposes of this subchapter:

(1) A claim is considered to be paid on an "assignment-related basis" if the claim is paid based upon the basis of an assignment described in subsection (b)(3)(B)(ii) of this section, in accordance with subsection (b)(6)(B) of this section, or under the procedure described in 1395gg(f)(1) of this title.

(2) The term "participating physician" refers, with respect to the furnishing of services, to a physician who at the time of furnishing the services is a participating physician (under subsection (h)(1) of this section); the term "nonparticipating physician" refers, with respect to

the furnishing of services, [to] a physician who at the time of furnishing the services is not a participating physician; and the term "nonparticipating supplier or other person" means a supplier or other person (excluding a provider of services) that is not a participating physician or supplier (as defined in subsection (h)(1) of this section.

42 U.S.C. §w-4(g)(a)(1)

(a) Payment based on fee schedule

(1) In general

Effective for all physician's services (as defined in subsection (j)(3) of this section) furnished under this part during a year (beginning with 1992) for which payment is otherwise made on the basis of a reasonable charge or on the basis of a fee schedule under section 1395m(b) of this title, payment under this part shall instead be based upon the lesser of -

(A) the actual charge for the service, or

(B) subject to the succeeding provisions of this subsection,

the amount determined under

the fee schedule established under subsection (b) of this section for services furnished during that year (in this subsection referred to as the "fee schedule amount").

42 U.S.C. §1395w-4(g)(3)

(3) Limitation on charges for medicare beneficiaries eligible for medicaid benefits

(A) In general

Payment for physicians' services furnished on or after April 1, 1990, to an individual who is enrolled under this part and eligible for any medical assistance (including as a qualified medicare beneficiary, as defined in section 1396d(p)(1) of this title) with respect to such services under a State plan approved under subchapter XIX of this chapter may only be made on an assignment-related basis.

(B) Penalty

A person may not bill for

physicians' services subject

to subparagraph (A) other than on an assignment-related basis. No person is liable for

payment of any amounts

billed for such a service in violation of the previous sentence. If a person knowingly and willfully bills for physicians' services in violation of the first sentence, the Secretary may apply sanctions against the person in accordance with

section 1395u(j)(2)
of this section.

42 U.S.C. §1395x(v)(1)(A)

(v) Reasonable costs

(1)(A) The reasonable costs of any services shall be the cost actually incurred . . . .

42 U.S.C. §1396a(a)(10)(B)

(a) Contents

A state plan for medical assistance must -

(10) provide

(B) that the medical assistance made available to any individual described in subparagraph (A) -

(I) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A). . . .

42 U.S.C. §1396a(a)(10)(E)

(a) Contents

A state plan for medical assistance must -

(10) provide

(E)(i) for making medical assistance available for medicare cost-sharing (as defined in section 1396d(p)(3) of this title) for qualified medicare beneficiaries described in section 1396d(p)(1) of this title . . . .

42 U.S.C. §1396a(a)(14)

(a) Contents

A state plan for medical assistance must -

(14) provide that enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges, may be imposed only as provided in section 1396o of this title. . . .

42 U.S.C. §1396d(b)

(b) Federal medical assistance percentage; State percentage; Indian health care percentage

The term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears tot he square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum . . . .

42 U.S.C. §1396o(a)

(a) Imposition of certain charges under plan in case of individuals described in section 1396a(a)(10)(A) or (E)(i)

The State plan shall provide that in the case of individuals described in subparagraph (A) or (E)(i) of section 1396a(a)(10) of this title who are eligible under the plan -

(1) no enrollment fee, premium or similar charge will be imposed under the plan (except for a premium imposed under subsection (c) of this section;

(2) no deduction, cost sharing or similar charge will be imposed under the plan with respect to . . . .

(3) any deduction, cost sharing, or similar charge imposed under the plan with respect to other such individuals or other care and

services will be nominal in amount (as determined by the Secretary in regulations which shall, if the definition of "nominal" under the regulations in

effect on July 1, 1982 is changed, take into account the level of cash assistance provided in such State and such other criteria as the Secretary determines to be appropriate . . .

42 U.S.C. §1396o(e)

(e) Prohibition of denial of services on basis of individual's inability to pay certain charges

The State plan shall require that no provider participating under the State plan may deny care or services to an individual eligible for such care or services under the plan on account of such individual's inability to pay a deduction, cost sharing, or similar charge. The requirements of this subsection shall not extinguish the liability of the individual to whom the care or services were furnished for payment of the deduction, cost-sharing, or similar charge.

42 U.S.C. § 1395cc(a)(2)(A)

A provider of services may charge such individual [a Medicare Part B beneficiary] or other person (I) the amount of any deduction or coinsurance amount imposed pursuant to section 1395e(a)(1), (a)(3), or (a)(4), section 1395*l*(b), or section 1395x(y)(3) of this title with respect to such items and services . . . and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services . . . for which payment is made under Part B of this subchapter. . . In the case of services described in 1395*l*(c) of this title, clause (ii) of the preceding sentence shall be applied by substituting for 20 percent the proportion which is appropriate under such section.
(Emphasis added.)

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

THE MARYLAND PSYCHIATRIC SOCIETY, INC., a District Branch of the American Psychiatric Association
1 1 0 1 St. Paul Street, Suite 305
Baltimore, MD 21202-6407

Civil No.

Plaintiff

v.

DONNA E. SHALALA
Secretary, Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

and *

MARTIN P. WASSERMAN, M.D., J.D., *
Secretary, Department of
Health and Mental Hygiene
of the State of Maryland *
Herbert R. O'Conor State
Office Building *
201 W. Preston Street
Baltimore, MD 21201 *

Defendants *

* * * * * * * * * *

COMPLAINT

Plaintiff, The Maryland Psychiatric Society, Inc., by its attorneys, Kathleen Howard Meredith, P.C., Stephan Y.

Brennan,
and Semmes, Bowen & Semmes, for their Complaint hereby allege:

PRELIMINARY STATEMENT

1. This is an action for injunctive relief and for a declaratory judgment brought by and on behalf of providers of outpatient psychiatric services to patients known as "Qualified Medicare Beneficiaries" ("QMB's"). QMB's are needy individuals who are eligible for Medicare and meet the statutory criteria for determining poverty but do not necessarily meet the income and resource requirements for full Medicaid eligibility. 42 U.S.C. §1396(p)(1).

2. Relief is sought from regulations promulgated by the State of Maryland's Department of Health and Mental Hygiene ("Department") which enable the State to reimburse health care providers, regardless of specialty, at an

amount less than the full amount of their reasonable

charges in connection with outpatient services provided to QMB'S.

3. Relief is also sought from a policy interpretation adopted by the Department which effectively prohibits psychiatrists from obtaining reimbursement for more than 62.5% of their reasonable charges in connection with outpatient services provided to QMB'S. (See copies of December 22, 1 993 letter from Plaintiffs to the Director of Maryland's Medical Care Policy Administration and reply letter dated January 10, 1 994, attached hereto as Exhibits 1 and 2, respectively.)

4. Finally, relief is sought from the Department of Health and Human Service's ("HHS") adoption of a policy

interpretation similar to that described in paragraph 3, supra, which provides for a reduction in reimbursement for providers of outpatient psychiatric services to QMB'S.

This policy interpretation was first articulated on behalf of HHS on June 1 1, 1 992, by Christine Nye, who was then the Director of the Medicaid Bureau at the Health Care Financing Administration (" HCFA"). (See copy of Ms. Nye's June 11, 1992, Memorandum attached hereto as Exhibit 3.)

Plaintiff

5. The Maryland Psychiatric Society, Inc. (the "Society") is a non-profit Maryland corporation with its principal place of business at 1101 St. Paul Street, Suite 305, Baltimore, Maryland 21202-6407. The Society is comprised of individual constituent members and of constituent members that are entities. All

of the Society's constituent members provide psychiatric services to patients within the State of Maryland, which include outpatient psychiatric and/or mental health services to the low income population of the State of Maryland, who are intended

beneficiaries under the Medicaid Act, the Medicare Act and the Medical Assistance Program ("MAP") of the State of Maryland. The Society is a large voluntary organization of physicians who practice within the psychiatric specialty in Maryland. The Society is organized to provide administrative assistance to its physician members, and one of its purposes is the enhancement of the delivery of high quality psychiatric care to all people, regardless of income or status, in the most efficient and accessible

manner possible, which will lead to the betterment of community mental health within the State of Maryland. Many of the Society's constituent members treat QMB'S,

including patients eligible for both Medicare and Medicaid ("Dual Eligibles"), on an outpatient basis.

6. At all times relevant hereto the constituent members of the Society provided outpatient psychiatric services to persons eligible to receive such services pursuant to the Medicare Act and the Medicaid Act.

Defendants

7. The Defendants herein are the State and Federal officials who are charged with the responsibility for the administration and implementation of the State of Maryland's Medicaid Program, also known as the Medical Assistance Program (MAP) and of the Medicare program under State and Federal law. The positions and duties held by Defendants are as follows:

(a) Defendant Martin P.

Wasserman, M.D., J.D., is, and was at all times relevant hereto, the Secretary of the Department of Health and Mental Hygiene of the State of Maryland. The Medicaid Act and Regulations promulgated thereunder require that states participating in the Medicaid program designate a single state agency to administer the State Medicaid program. Maryland's MAP and regulations promulgated thereunder contain similar requirements. The Department of Health and Mental Hygiene (Department) has been so designated under Maryland's MAP.

(b) Defendant Donna A. Shalala is, and was at all times relevant hereto, the Secretary of the United States Department of Health and Human

Services (HHS). She is the federal officer responsible for administration of the Medicare Act and the Medicaid Act. The Medicaid Act confers upon the Secretary of HHS the responsibility for the review and approval of those state plans for medical assistance, amendments

thereto, and implementation thereof, which conform to the requirements of the Medicaid Act, and it directs the Secretary of HHS to take steps to compel participating states that fail to comply with the Medicaid Act to comply therewith.

Jurisdiction and Venue

8. This action arises under the Medicare Act, 42 U.S.C. § § 1395, et seq, and the federal regulations promulgated thereunder; the Medicaid Act, 42 U.S.C. § § 1396 et seq, and the federal regulations promulgated thereunder; 42 U.S.C. § 1983;

and Article VI of the Fourteenth Amendment to the United States Constitution.

9. Jurisdiction is conferred upon this Court under 28 U.S.C. §§ 1331m, 1343, 1361, 2201 and 2202.

10. Venue is proper in this District under 28 U.S.C. § 1391(b).

Historical Background

A. The Medicare Program

11. The Medicare Program, established in 1965 under Title XVIII of the Social Security Act, 42 U.S.C. § § 1395, et seq., provides for a program of federal reimbursement for medical care for the aged and disabled.

12. The Medicare Act consists of two parts. Part A of Medicare, 42 U.S.C. §§ 1395c - 1395i-2, covers inpatient services furnished by hospitals and other

institutional providers, and is financed by Social Security payroll contributions. Part A services are not the subject of this litigation.

13. Part B of the Medicare Act, 42 U.S.C. § § 1395j - 1395w, is a voluntary program which provides supplemental insurance benefits for certain medical and other health services, including physician services and outpatient hospital services and supplies. The Part B program is funded by

premium payments of enrollees and contributions from the federal government. In addition to monthly premium payments, most individuals must pay an annual deductible charge and a coinsurance amount for each service provided under Part B.

14. Payments to health care

providers for Part B services rendered to Medicare-eligible patients are based upon "reasonable charges" if the health care providers are physicians and upon "reasonable costs" in the case of hospitals. Such "reasonable" costs and charges are computed pursuant to the Medicare Act and the regulations promulgated thereunder. § 1395w - 4(a)-(b).

15. The Medicare program typically pays 80% of such reasonable charges and costs for the benefit of eligible individuals. In most instances, Part B enrollees are liable for the "cost-sharing" amounts, i.e., the

deductible and the amount necessary to reimburse the health care provider for the full amount of his reasonable charges after Medicare has paid its share of the charges under the Act.

B. The Medicaid program

16. The Medicaid program was established concurrently with the Medicare Program pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1 396 at zm, and was intended to provide medical services to the poor through a program jointly funded by the federal government and by the respective governments of the states.

17. Federal funds provided to the states pursuant to the Medicaid program provide a major portion of the cost of state medical assistance programs and are made available to those states that have Medical Assistance Plans ("MAP's") that I have been

approved by the Secretary of HHS in accordance with 42 U.S.C. §§1396(a) and

(b).

18. The State of Maryland has elected to participate in the Medicaid program and has a MAP that has been approved by the Secretary. This MAP sets forth the State's agreement to administer the MAP in accordance with the requirements of the Medicaid Act.

19. Pursuant to the Medicaid Act and Maryland's MAP, covered services are rendered to eligible individuals by health care providers, including Plaintiffs, in exchange for payments made by the Medicaid program.

20. Payment rates for services provided under the Medicaid program are established by the States under their MAP's and are generally not based on the same schedule for "reasonable costs" or

"reasonable charges" established under the Medicare Act.

21. The State of Maryland has established Medicaid reimbursement rates

under its MAP which are, in most instances, lower than the "reasonable cost" or "reasonable charges" established by Medicare Part B for the same services.

c. State Buy-In Agreements

22, Due to Congress' recognition that the charges to recipients of services under Medicare Part B, i.e., deductible, premium and responsibility for coinsurance payments to ensure reimbursement to providers of 100% of the providers' of reasonable costs", might deter poor Medicare-eligible individuals from enrolling for Part B coverage, the Medicare Act originally provided a

mechanism by which states could enroll, at their option, the poorest of Medicate-eligible individuals, i.e.,

those individuals whose poverty also made them eligible for Medicaid and who thus became known as "Dual Eligibles", in the Part B program by entering into "buy-in" agreements with the Secretary of HHS.

23. The Medicaid Act required that when states enrolled their "Dual Eligibles" in the Part B Medicare Program, the state
MAP's had to assume Dual Eligibles obligations to pay the Medicare deductibles and coinsurance amounts, as well as the Part B insurance premiums. 42 U.S.C. § 1396(a)(a)(15)[repealed].

24. In 1988, Congress recognized that coverage of Dual Eligibles under

buy-in agreements was not sufficient to facilitate the legislative goal of access to high quality medical care for all individuals, particularly the poor. Therefore, Congress expanded the opportunity for the poor to be enrolled in Medicare Part B by amending the Medicaid

Act to require that participating states enroll not only Dual Eligibles but also those persons categorized as "Qualified Medicare Beneficiaries" ("QMB's") in the Part B Medicare program. 42 U.S.C. § 1396a(a)(10)(E). QMB's are needy individuals who are eligible for the Medicare program and meet statutory criteria established to determine poverty but do not necessarily meet the income and resource requirements for full Medicaid eligibility. 42 U.S.C. §

1396(p)(1).

25. The Medicaid Act was further amended to require that state MAP's pay Medicare "cost sharing" on behalf of all QMB'S, and Congress expanded the definition of QMB to include all Medicare-eligible individuals whose income falls below federal poverty levels, thus including within the definition.of QMB's those persons who are also Dual Eligibles.

42 U.S.C. §1396a(10)(E).

26. The Medicare Act was amended in 1989 to require that physicians treating QMB's (including Dual Eligibles) only bill for such services on an "assignment related basis", and that payments for such services only be made on an "assignment related basis", thereby precluding physicians from "balance

billing" QMB'S. 42 U.S.C. § 1395w-4(g)(3)(A).

27. QMB's are primarily Medicare patients, and the services provided to QMB's are primarily Medicare services, even though some QMB's are also provided benefits under the Medicaid Act.

28. Health care providers are entitled to full reimbursement for their "reasonable charges" connected with the provision of Medicare Part B services. 42 U.S.C. § § 13951, 1395cc(a)(2)(A), 1395w-4(a)(1) and 1395u(b)(3)(B).

The Regulations and Policies Challenged

A. The Maryland Regulations

29. Regulations promulgated by Maryland's Department of Health and Mental Hygiene ("Department") enable

the State to limit the total payments for covered services under Maryland's MAP to the Medicaid rate or fee for that particular service. The MAP rate of payment is the Medicaid rate of payment. Therefore, when the Medicaid rate of payment or reimbursement to physicians is lower than the Medicare Part B rate, which is generally the case, health care providers can be deprived of full reimbursement for their "reasonable charges" under Medicare Part B with regard to outpatient services provided to QMB's under Maryland's MAP. COMAR §§10.09.36.03(A)(6) and 10.09.36.07.

30. Payments for Part B services are only authorized under Maryland's MAP where the provider accepts

Medicare assignments and is paid directly by Medicare after submitting a bill directly to Medicare, pursuant to Medicare guidelines. COMAR § 10.09.02.07(H).

31. Maryland's regulations also provide that supplemental payments under the State MAP on Medicare claims are made subject to: (1) full payment of the deductible insurance; (2) full payment of coinsurance; and (3) payment for services not covered by Medicare are payable at the lower of the physician's customary charge or the Department's fee schedule, at the State's option. COMAR §§10.09.02(E) and (G).

32. Chapter 24 of Subtitle 9 of Title 1 0 of COMAR, § 10.09.24.01 et seq. establishes the eligibility criteria for

"participants", i.e., patients, under the State

MAP, which are consistent with federal requirements under §1902 of the Social Security Act.

33. Chapter 36 of Subtitle 9 of Title 10 of COMAR, §10.09.36.01 establishes the criteria for provider, i.e., health care provider, participation under the State MAP. Participating providers are required to have a current "provider agreement" with the Department under which the providers are assigned individual account numbers; to submit requests for payment directly to the Department; and to accept payment under the MAP as payment in full for their services without making any additional charge to any other person for such services. COMAR §§10.09.36.01(B)(13), 10.09.36.03(A)(4), 10.09.36.03(A)(6)and lO.09.36.04(A).

34. The challenged regulations

thus
require the providers of medical services under Maryland's MAP, including Plaintiff's members, to accept Medicare assignments while enabling the State to limit its payments under the MAP to the Medicaid rate, thus effectively treating participants in the MAP, including QMB's, as Medicaid rather than Medicare patients and also effectively precluding such providers from demanding full reimbursement for services provided to OMB'S.

B. The HHS/HCFA and Department Interpretation of the Reduction in Reimbursement for Outpatient Psychiatric Services and Policy of Reimbursement to Providers of Such Services that is Challenged

35. Under 42 U.S.C. § 1395(c), only 62.5% of the expenses incurred in any calendar year for services described herein as "outpatient psychiatric services" are considered as "incurred expenses" for purposes of subsections (a) and (b) of 42 U.S.C. §13951, which pertain to the calculation of payments to be made from Medicare Part B for those services and to the calculation of deductibles, respectively.

36. Under 42 U.S.C. § 13951(a), Medicare Part B typically pays, through the Federal Supplemental Medical Insurance Trust Fund, established at 42 U.S.C. § 1395t, 80% of the reasonable charges or costs for providers' services. Therefore, the "coinsurance" necessary to ensure that providers receive full reimbursement for their "reasonable charges" associated with

the provision of services covered by Medicare Part B is typically 20%.

37. When 42 U.S.C. §13951(a) is read in conjunction with 42 U.S.C. §

13951(c), only 80% of 62.5% of the provider's reasonable charges for outpatient psychiatric services is paid by Medicare Part B from the Trust Fund, i.e., 50% of the provider's reasonable charges. (62.5% x 80% = 50%).

38. Despite the fact that the 50% of unpaid "reasonable charges" under 42 U.S.C. § 13951(c) is analogous to the 20% of "reasonable charges" that is typically left unpaid by Medicare Part B and must be paid by the States after Medicare Part B makes its customary primary payment, HHS/HCFA have adopted an interpretation of 42 U.S.C. §13951(c) that only requires the States

to pay 20% of the 62.5% of, "reasonable charges", i.e., 12.5% of the "reasonable charges". (20% x 62.5% 12.5 %). (Exhibit 3.)

39. The remaining 37.5% of the "reasonable charges" of providers of

outpatient psychiatric services to QMB's under Medicare Part B is completely excluded under the HHS/HCFA analysis from either Medicaid or Medicare payment; although the States are permitted to pay such amounts with their own funds if they should so choose. (Exhibit 3.)

40. HCFA/HHS also takes the position that the QMB's may be billed by the providers for the unpaid 37.5% of "reasonable charges". (Exhibit 3.)

41. The Department of Health and Mental Hygiene of the State of

Maryland (Department) interprets the relevant provisions of the Medicare Act in a manner consistent with the HHS/HCFA interpretation, so that it only reimburses health care providers, including the Plaintiff's members, 12.5% of their reasonable charges for outpatient psychiatric

services to QMB's as a copayment under Maryland's MAP. (20% x 62.5% = 12.5%). (See Exhibits 1 and 2.)

42. Under the current HHS/HCFA and Department interpretations of 42 U.S.C. § 13951(c), the Plaintiff's members and other similarly situated providers only receive 62.5% of their reasonable charges for the provision of outpatient psychiatric services to QMB's (including Dual Eligibles), and the

Plaintiff's members and other similarly situated providers are effectively required to either bear 37.5% of the cost of providing such services or to decline the assignment of QMB's, i.e., decline to participate in the State MAP.

43. Therefore, those who provide outpatient psychiatric services in the State of Maryland under Medicare Part B, including the Plaintiff's members, do not receive full reimbursement or compensation for their

reasonable charges, as is their right as providers of covered services to QMB's under Medicare Part B.

Count I

44. Plaintiff repeats and realleges each and every allegation in paragraphs 1 - 43, inclusive, of this Complaint, as if fully set forth herein.

45. The Medicare Act and the implementing regulations thereof entitle providers of Part B services to QMB's (including Dual Eligibles) to receive reimbursement for their "reasonable costs" or "reasonable charges" for such services.

46. The Medicare Act entities providers of Part B services to charge either the Medicare beneficiary, in appropriate cases, or some "other person", the amount of any deduction or any coinsurance amount established pursuant to statute. 42 U.S.C. §1395cc(2)(A).

47. Ordinarily, the "coinsurance" or "copayment" under Medicare Part B is equal to 20% of the reasonable costs or charges for items or services provided, and when this 20% is paid the provider receives full reimbursement for his

reasonable costs or charges, pursuant to the mandate of the Medicare and Medicaid Acts. However, 42 U.S.C. § 1395cc(2)(A) specifically requires providers to substitute the relevant proportion under 42 U.S.C. § 13951(c), i.e., 50%, for the customary 20% figure.

48. Given the fact that providers of Part B services are prohibited from "balance billing" QMB's (including Dual Eligibles) for the provision of such services, and given the fact that the State MAP, i.e., Medicaid, is an "other person" within the meaning of the statutory scheme, the interpretation adopted by HHS/HCFA and the Department limiting reimbursement to those Part B providers who provide outpatient psychiatric services to QMB's (including Dual Eligibles) to 62.5% of the reasonable charges for such

services violates the Medicare Act.

49. The right of providers of Part B services to recover their reasonable costs and charges, in the form of Medicare Part B primary payments and the payment of coinsurance is mandatory under the Medicare and Medicaid Acts.

50. The relevant MAP regulations in Maryland, and the HHS/HCFA and Department anterpretations of 42 U.S.C. §13951(c) and the concomitant policy of reimbursement to providers of outpatient psychiatric services to QMB's (including Dual Eligibles), deprive providers of the ability and the right to receive compensation and reimbursement for their "reasonable costs" and "reasonable charges" and, therefore, violate the Medicare Act.

51. Consequently, the challenged regulations, interpretations and reimbursement policy are unlawful and invalid and are arbitrary, capricious, an abuse of discretion, and otherwise not in accordance with the law.

Count II

52. Plaintiff repeats and realleges each and every allegation contained in paragraphs 1-43 of this Complaint, inclusive, as if fully set forth herein.

53. The Medicare Act and implementing regulations provide that the costs of the Medicare program be borne entirely by that program and not borne by others.

54. Medicare regulations recognize that, to the extent that providers do not receive reimbursement for their reasonable costs or charges, the costs of the Medicare program are being unlawfully shifted to

others.

55. Any shifting of the costs of Part B services to either QMB's (including Dual Eligibles) or to the providers of outpatient psychiatric services to such patients is violative of the Medicare Act and its implementing regulations.

56. The challenged MAP provisions, as well as the challenged HHS/HCFA and Department interpretations of 42 U.S.C. § 13951(c) and the resultant policy of reimbursement to providers of outpatient psychiatric services to QMB's (including Dual Eligibles), prevent such providers, including Plaintiff's members, from recovering, reimbursement from the State or from the QMB's for amounts not paid by Medicare Part B. The challenged regulations, interpretation and reimbursement policy also may result in such costs being

shifted to individuals not covered by the

Medicare program and they have, in any event, resulted in costs being shifted to the providers, including Plaintiff's members, which is violative of the Medicare Act and its implementing regulations.

57. The challenged policies, regulations and interpretations are, therefore, unlawful, invalid, arbitrary, capricious and an abuse of discretion, and are otherwise not in accordance with the law.

Count III

58. Plaintiff repeats and realleges each and every allegation contained in paragraphs 1-43, inclusive, of this Complaint, as if fully set forth herein.

59. The Medicaid Act, 42 U.S.C. § 1396 et seq., provides that each State

MAP must contain provisions that only allow for the imposition of, at most, "nominal" cost sharing on recipients of Medicare Part B services, particularly QMB's (including

Dual Eligibles), even when those recipients can be lawfully billed for a certain amount
of the "reasonable charges" for Medicare Part B services. 42 U.S.C. § 1396(o).

60. The current HHS/HCFA and Department interpretations of 42 U.S.C. 13951(c) and the resultant policy of reimbursement to providers of outpatient psychiatric services to QMB's (including Dual Eligibles), which is to the effect that providers can "balance bill" QMB's for 37.5% of the providers' reasonable charges (see, Exhibit 3), violates the spirit and the

letter of the Medicaid Act and the Medicare Act, and is contrary to the legislative history of the Acts, in addition to being contrary to HHS/HCFA's 1989 interpretation of the same provision (see, copy of 1989 HCFA Memorandum attached hereto as Exhibit 4), and it is erroneous.

61. The 37.5% of the reasonable costs or charges not covered under the Department's and HHS/HCFA's current interpretation of 42 U.S.C. § 1 3951(c) and the resultant reimbursement policy is coinsurance and cost-sharing within the meaning of the Acts, as is evidenced by the legislative history of 42 U.S.C. § 13951(c) and thus must be paid by the State MAP.

62. Billing QMB's for 37.5% of

"reasonable charges" for outpatient psychiatric services would impose more than the "nominal" cost-sharing on QMB'S, in violation of the Medicaid Act and regulations promulgated thereunder.

63. The State's failure to pay the disputed 37.5% of reasonable charges for outpatient psychiatric services provided to QMB's (including Dual Eligibles) violates the Medicaid Act and is unlawful and invalid, and the Secretary's actions with respect thereto are arbitrary, capricious, an

abuse of discretion, and are otherwise not in accordance with the law.

Count IV

64. Plaintiff repeats and realleges each and every allegation contained in paragraphs 1-63, inclusive, of this

Complaint, as if fully set forth herein.

65. The regulations challenged herein, as well as HHS/HCFA's and the Department's interpretation of 42 U.S.C. § 13951(c) and policy for reimbursement of reasonable charges to providers of outpatient psychiatric services to QMB's (including Dual Eligibles), arbitrarily and capriciously deprives such providers, including Plaintiff's members, of their property interest in payment for their reasonable charges, as mandated by Congress, in violation of the Due Process Clause of the Fourteenth Amendment to the United States Constitution.

66. Plaintiff's members have suffered and will continue to suffer irreparable injury for which they have no

adequate remedy at law.

WHEREFORE, Plaintiff respectfully requests that:

(1) This Court declare and adjudge that:

(a) The challenged regulations under the State MAP are unlawful, unconstitutional or invalid, and that the State's implementation of such regulations is unlawful and invalid;

(b) The Secretary's interpretation of 42 U.S.C. § 13951(c) and the effects thereof, as exemplified in Ms. Nye's 1992 HCFA Memorandum (Exhibit 3) is arbitrary, capricious, an abuse of discretion, invalid and otherwise not in accordance with the law; and

(c) That the entire 50% of the

reasonable charges of providers of

outpatient psychiatric services to QMB's (including Dual Eligibles) is coinsurance, copayment or cost sharing within the meaning of the Medicare and Medicaid Acts and must be borne by the State MAP; and that

(2) This Court permanently enjoin:

(a) Defendant Wasserman and his successors, officers, agents, servants and employees from implementing or attempting to implement the Secretary's current interpretation of 42 U.S.C. §13951(c) and the effects thereof, i.e., that Defendant Wasserman and his successors, agents, officers, servants and employees cease forevertheir efforts to limit copayment underthe State MAP for outpatient psychiatric services to QMB's (including
Dual Eligibles) to 12.5% of the providers' reasonableI charges and instead pay the

50% coinsurance or copayment not paid by

Medicare Part B;

(b) The Secretary of HHS and Defendant Wasserman and their successors, officers, agents, servants and employees from approving any regulation, or interpreting and implementing any regulation or statute in such a manner that would eliminate, reduce, or impinge upon providers's rights to receive full payment for I reasonable costs or charges for Part B services.

(3) Plaintiff be awarded its costs and attorney's fees; and

(4) Plaintiff be awarded such other and further relief as this Court may deem just and proper.

Respectfully submitted,

Kathleen Howard Meredith, P.C.
Federal Bar Id. No. 00701

Stephan Y. Brennan

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Baltimore, Maryland 21201
(410) 539-5040

Attorneys for Plaintiff,
The Maryland Psychiatric Society, Inc.

EXHIBIT 1[3]

MARYLAND PSYCHIATRIC SOCIETY

December 22, 1993

Joseph Millstone, Director
Medical Care Policy Administration
201 West Preston Street, Room 127
Baltimore, MD 21201

Dear Mr. Millstone:

The Maryland Psychiatric Society is concerned about the method of reimbursement to psychiatrists by the Qualified Medicare Beneficiary (QMB) program. Until recently, psychiatrists were being reimbursed 80% by Medicare for

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[3]Exhibit in format originally submitted to the trial court is lodged in the Clerk's Office pursuant to Rule 32 of the Rules of the Supreme Court of the United States.

services provided, similar to all other medical specialties. With the 1993 payment reform, the reimbursement for outpatient services provided by psychiatrists was changed to 50% based upon a 62.5% reduction for outpatient psychiatry services (0.625 times 80% = 50%) and psychiatrists have been required to charge the patients the remaining 50% balance. In 1992, the Director of the Medicaid Bureau at HCFA, Christine Nye, put out an opinion that copayment by the Medicaid program for qualified Medicare beneficiaries should be 12.5% and that the remaining 37.5% is not an "incurred expense" to the states. As you know, this reduction is calculated by using 62.5% of the Fee Schedule Amount and then using 80/20 for payment/copayment.

This recent opinion goes against the directive of Medicare to regard 50% copayment as an

incurred expense to the beneficiary, the effort by Medicare to weight cognitive services in their Physician Payment Reform, and specifically discriminates against mental health care and mental health care providers. We believe this opinion is wrong and the use of the 62.5% outpatient reduction is inappropriate and redundant. It amounts to double discrimination against mental health treatment.

Many psychiatrists avoid the elderly population because of the low payment for their services. Maryland nursing homes, outside of a few in the Baltimore area, cannot find psychiatrists for routine problems. Psychiatrists who accept Medicare patients in the office are becoming rare. We believe that discriminatory interpretations like this one by the QMB program at HCFA have a marked negative affect on availability

of psychiatric care for the elderly in Maryland.

Psychiatrists should receive full reimbursement for copayment and deductibles as do all other medical specialists. The current practice of 12.5% copayment by the Medical Assistance Program of Maryland is not valid based on any reasonable argument, and Maryland should not accept the option of paying in this manner. Balancing the budget on the backs of the needy is not justifiable. Full reimbursement by the Medical Assistance Program for QMBs would greatly benefit the elderly and chronically mentally ill.

Sincerely,

William C. Wimmer, M.D.
President

Jeffrey Lafferman, M.D.
Chair, Geriatric Psychiatry Committee

EXHIBIT 2[4]

STATE OF MARYLAND

Medical Care Policy Administration

Department of Health and Mental Hygiene

January 10, 1994

Jeffrey Lafferman, M.D.
William C. Wimmer, M.D.
Maryland Psychiatric Society
1101 St. Paul Street
Suite 305
Baltimore, MD 21202-6407

Dear Drs. Lafferman and Wimmer:

Thank you for your recent letter concerning the Program's method of calculation of co-payments for psychiatric

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[4]Exhibit in format originally submitted to the trial court is lodged in the Clerk's Office pursuant to Rule 32 of the Rules of the Supreme Court of the United States.

services rendered to Medicare patients.

The Program understands your position concerning the calculation of co-payments by Medicaid, but is unaware of any successful challenges to the interpretation of the Medicaid Bureau at HCFA. Currently, there are no additional funds available to increase the Medicaid fees to physicians, dentists or psychologists. As a result we are not in a position to be able to afford increasing any payments at this time.

Access to medical care is always of concern. It was for the very reasons that you state in your letter that discussions during previous legislative sessions have included mandatory Medicare and Medical Assistance assignment. Discrimination against patients who are required to participate in Federal Programs such as Medicare, is of great concern. It is of no less concern than adequate access to services by Medicaid

Recipients who are not also covered by Medicare. If you have compiled data concerning access to care I would appreciate receiving a copy.

Once again, thank you for taking the time to bring these matters to my attention and for your interest in the Program.

If you have any further questions, please feel free to contact Dr. Edward Watters, Physician Advisor, at 225-1482.

Sincerely,

Joseph M. Millstone

Director

cc: Edward Watters, III, M.D.

EXHIBIT 3[5]

DEPARTMENT OF HEALTH & HUMAN SERVICES

MEMORANDUM

Date:	June 11, 1992
From:	Director Medicaid Bureau
Subject:	Medicaid Co-Payments for Medicare Outpatient Psychiatric Services
To:	Associate Regional Administrator Region 1V, Atlanta Attention: Division of

[5]Exhibit in format originally submitted to the trial court is lodged in the Clerk's Office pursuant to Rule 32 of the Rules of the Supreme Court of the United States.

Medicaid

This is in reply to your request for clarification of the above referenced subject. Attached to your memorandum, you provided copies of our April 7, 1989 memorandum and a letter from the Georgia Department of Medical Assistance requesting a formal review of the policy contained in that memorandum.

The issue involves the unique character of the 62 and 1/2 percent reduction in section 1833(c) of the Social Security Act (the Act) for services for the treatment of mental, psychoneurotic, or personality disorders of an individual who is not an inpatient of a hospital. The question concerns whether the 27 and 1/2 percent remainder, which is excluded from the Medicare incurred amount in determining Medicare's payment, is a

coinsurance under Medicare which States are

required to pay towards as Medicare cost-sharing for Qualified Medicare Beneficiaries (QMBs).

The distinction is important because the term "medicare cost-sharing" is expressly defined in section 1805(p)(3) of the Act as follows:

> A)(1) premiums under Section 1818 or 1818A, and (ii) premiums under section 1839;
>
> B) Coinsurance under title XVIII (including coinsurance described in section 1813;
>
> C) Deductibles established under title XVIII (including those described in section 1813(a) in section 1833(b); and,
>
> D) the difference between the amount that is paid under section 1833(a) and

the amount that would be paid under such section if any reference to "80 percent" therein the deemed & reference to "100 percent".

In the April 7, 1989 memorandum, MCFA took the position that 37 and 1/2 percent of the reasonable charge remaining after the reduction was applied was a coinsurance amount. Although MCFA recognized that this amount was not normally called coinsurance in Medicare issuances, it found that it was similar to coinsurance in that it is an amount which Medicare does not pay and which a provider may collect from the beneficiary.

Section 1833(c) of the Act does not expressly refer to the remainder following application of the statutory percentage as a coinsurance amount. Ragher, the statute uses the 62 and 1/2 percentage to reduct the

amount recognized as an incurred expense for the purpose of determining Medicare reimbursement. Further, regulations at 42 CFR 410.155(c) recognize this distinction by labeling the reduction as a "Limitation on incurred expenses." Medicare policy does not classify the remainder as a coinsurance amount, but identifies a separate amount representing coinsurance (20 percent of total covered expenses less deductible). Although section 1866(a)(2)(A) of the Act authorizes participating providers to charge the beneficiary for the 37 and 1/2 percent that Medicare does not consider incurred, it does not characterize this amount as coinsurance.

We believe that Georgia has advanced legitimate arguments that States should not be required to pay this additional amount for QMBs. The remainder following the 62 and 1/2 percent redection is not labeled

coinsurance under the statete, regulations, or section 2170 of the Medicare carriers Manual.

Therefore, Medicaid will not require States to pay toward the 37 and 1/2 percentage which is excluded from incurred cost as a coinsurance amount. If a State has elected not to cover this service under its plan, as Georgia suggests in the case here, the State may only be compelled to pay Medicare cost-sharing for the service. (A State could elect to pay a higher amount under its State Plan for outpatient psychiatric services for QMBs than is provided for other Medicaid recipients if the services are covered under the State's plan. This higher amount may reasonably include the 37 and 1/2 percent remainder). The State would be obliged to pay toward the Medicare deductible and the 20 percent coinsurance in accordance with

the Medicaid manual, which provides that States may establish reasonable payment rates for non-covered services up to the Medicare rate.

In summary, because the State's payment is full satisfaction of the Medicare cost-sharing amount, but the 37 and 1/2 percent is not cost-sharing, the provider could attempt to collect that amount from the QMS.

This memorandum sets aside the position HCFA took in our memorandum of April 7, 1989 to the Regional Administrator, Kansas City on this subject.

If you have any questions, please call Mark Ross at FTS. (410) 966-5855

Christine Nye

cc: All Associate Regional Administrators

EXHIBIT 4[6]

APR 7 1989

Acting Director

Bureau of Eligibility, Reimbursement and Coverage

Missouri Medical Program Outpatient Psychiatric Services - Payment of Coinsurance on Medicare Crossover Claims (Your Memorandum Dated December 21, 1988) - INFORMATION

Regional Administrator

Region VII, Kansas City

Attn: Division of Program Operations

This is in response to your memorandum on Missouri's concerns regarding the amount of

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[6]Exhibit in format originally submitted to the trial court is lodged in the Clerk's Office pursuant to Rule 32 of the Rules of the Supreme Court of the United States.

coinsurance they are obligated to pay to a provider on Medicare crossover claims for outpatient psychiatric services.

Assuming that the Part B annual deductible has previously been met, and that the approved charges for outpatient psychiatric services do not exceed the fixed dollar limitation on those charges for the year ($2200 for 1989 and later years), Medicare pays 80 percent of 62.5 percent of the approved charges for these services. The State asks whether its coinsurance responsibility under Medicaid is 20 percent of 62.5 percent of the approved charges for the services, or that amount plus 37.5 percent of those approved charges.

While the 37.5 percent of approved charges referred to is not usually called a coinsurance in Medicare administrative issuances, that is

what it, in fact is. Therefore, the State is responsible for 37.5 percent of the approved charges, plus 20 percent of the remainder of those charges, for outpatient psychiatric services, in the situation described. The state may, of course, pay some lesser amount or amounts as payment in full toward these coinsurances as indicated below.

As the above guidance applies to the case of outpatient psychiatric services, the State must establish its payment rate for such service in accordance with the instructions in the SMM. Accordingly, the State has the option of establishing the amount that it will pay for a QMB as coinsurance for the service, which could be the amount already set in the State Plan if the service is covered by Medicaid, or any reasonable amount up to the Medicare approved amount.

With regard to patient liability, if the provider accepts Medicare assignment, because of State law or for any other reason, Medicare's payment plus whatever Medicaid pays toward the Medicare deductibles and coinsurance, is considered payment if full for the services. Other than any patient liability established in the State plan for nominal cost-sharing under Medicaid, whatever Medicaid pays for a QMB toward the Medicare coinsurance for a particular service is considered payment in full for Medicare cost-sharing and the patient cannot be billed for any difference in payment representing Medicare deductibles or coinsurance. A recipient may be billed, however, only for the difference between the provider's charge and Medicare's reasonable charge in those cases where the provider does not accept Medicare assignment and the recipient is a QMB only, that is, he is not otherwise

eligible for Medicaid benefits, or, if the QMB is otherwise eligible for Medicaid benefits, the provider does not serve Medicaid recipients other than QMBs or the service is not covered under the State plan.

If you have any questions concerning or its application to Missouri's questions, the QMB instructions please contact Robert Nakielny at FTS 646-4466.

Kathleen A. Buto